MENTAL HYGIENE

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DO ALIENISTS DISAGREE?

IS THE INSANITY PLEA BUNK?

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"INSANITY'S bunk—and alienists sell opinions. If they don't, why can't they agree?"

Mrs. Estelle Lawton Lindsay, of the *Los Angeles Express,* in commenting on the trial of William Edward Hickman, kidnaper and murderer, thus purported to quote a business man, a man of keen common sense.

"This much stands out from the Hickman trial", Mrs. Lindsay continues. "People are weary to death of insanity as a defense in murder cases. . . . People simply do not believe that Hickman is anything but sane, calmly and permanently sane, and they will continue to believe that, regardless of how many insane ancestors the young men who are defending this icy outlaw may produce. They believe that he is sane and that the effort to prove him otherwise is a ruse to save a neck that is overdue to be cracked."

Mrs. Lindsay is an "expert" on matrimonial problems, conducting a column in the *Los Angeles Express* called *The Log of the Good Ship Marriage.* It seems to be a rule of all newspapers never to publish any article on a psychopathic murder case by a psychiatrist or a bona fide psychologist. But however little Mrs. Lindsay may be qualified to pass on this youth's mental state, she is at least correct in her interpretation of the mood of the people, which holds that because one alienist is testifying on one side and another alienist

on the other, the alienist is selling his opinion—at least, the alienist for the defense. "For if not, why don't they agree?"

Agree on what? The alienists themselves seem not to have thought this out clearly. For what purpose are psychiatrists summoned in these cases? Bear in mind, it is the sensational murder case now under consideration, not the case in which the mental trouble of the accused is so obvious that the defendant is not brought to trial, but a lunacy commission is appointed. It is the border-line case only that is responsible for the distrust of the alienist.

Is the psychiatrist in the courtroom to ascertain the mental condition of the defendant, to make a diagnosis? Not at all. Were that the issue, as it is on a lunacy commission or in the clinic and laboratory, there would be no essential disagreement. But the alienist is not there for that. That is merely incidental and of interest only to himself and his fellow psychiatrists. He is there to give an opinion, not upon a medical question, but upon a metaphysical question, a question grounded in the realm of mysticism. This metaphysical question, the law, still floundering in the mire of precedent accumulated before anything was known of the mechanics of human behavior, still holds to be the crucial test in a criminal trial—namely, has the accused sinned? If so, did he realize that he was sinning? For if he realized it, he ought to be punished.

Now what relation has this question to psychiatry? Of course the law does not use these Mosaic terms formally any more. But the spirit of mysticism still remains. The psychiatrist is summoned to give an expert(?) opinion as to whether, if the accused committed the act, he did so with the knowledge that he was doing wrong. Did he have sufficient mental capacity to know that the act was wrong? If he did, the law (not the psychiatrist) declares him sane. If he did not, the law declares him insane. For the law does not consult the expert as to what insanity is; the law makes a definition of its own to which the expert must adhere. Not so long ago priests were called on to answer these questions regarding "sin". Modern (so-called) criminal law has retained the priestly type of question, but has changed the type of person summoned to answer it. The scientist is trying to be

the priest. It would have been wiser to have left it with theology perhaps, for at least the theologian would take it seriously, while the medical expert knows that he is being placed in a false position. What wonder that when experts begin to testify, the jury feel that they may begin to drowse? And they do so, while the experts are made to look like pompous fools, forced as they are to attempt to answer professionally a question that has no place in their profession, a question that, lying as it does in the field of emotions and prejudices, they are no more fit to answer authoritatively than are other men—namely, the question of moral responsibility and of "free will". This is the question that they are forced by the law to dispute over, not their scientific findings regarding the mental condition of the prisoner at the bar, who, professionally speaking, is not a good man who ought to be saved or a bad man who ought to be punished, but in all probability a man from whom, both the experts for the prosecution and the experts for the defense earnestly agree, society should be protected.

A concrete case will illustrate the situation. The defendant was accused of a bank hold-up, and his attorney entered a plea of insanity. He was compelled to call the mental condition of the defendant "insanity", although he believed the youth to be feebleminded. The law does not recognize such terms as "moron", "imbecile", or "idiot". Five medical experts testified, two for the prosecution and two for the dedefense, while a fifth was summoned by the judge, in order that the jury might have the benefit of an unbiased opinion. This fifth witness was Dr. Edward Huntington Williams, of Los Angeles, a psychiatrist and criminologist of national reputation and the author of a number of books. All these five men examined the defendant and testified practically to the same facts. They affirmed that the defendant, twenty-three years old, showed every evidence of having suffered since childhood from a disease that affected the pituitary gland and that had retarded his mental development, just as it had dwarfed him physically. They affirmed that the youth was a moron. They fixed his mental age as between eight and twelve or fourteen years.

"Now, Doctor", finally would come the crucial question,

"in your opinion was the defendant, at the time he committed this crime, of sufficient mental capacity to appreciate the nature and quality of his act and to know that his act was wrong?"

"Yes", replied the two experts for the prosecution.

"No", replied the two experts for the defense.

"Yes", replied Dr. Williams.

The jury agreed with Dr. Williams and the experts for the prosecution, and this youth is now in San Quentin Penitentiary. For as Dr. Williams himself, and his coadjutor, Dr. Ernest Hoag, declare in their book, *Crime, Abnormal Minds, and the Law,*[1] "most of our courts permit us to hang children of seven years, for no matter what age a man may be, if his mind is that of a child, *he is a child* as far as responsibility goes".

And yet Dr. Williams, although believing that this young man had the mind of a child, testified for the prosecution. He was under oath and believed that this child knew it was wrong to try to rob a bank. And he said so. Conscientious? Assuredly.

Drs. Williams and Hoag have also this to say:

> "Now the knowledge of right and wrong is no real test of responsibility; what is a test is the ability to *act* on such knowledge. Even young children possess the knowledge of right and wrong, but no reasonable person expects them to always act responsibly. Animals possess such knowledge to some degree, at least by training. The feebleminded, except the lowest of them, all have some knowledge of right and wrong, but in a true sense they do not possess such knowledge because moral responsibility is based on judgment; and judgment in the feebleminded is not much developed. Accordingly the feebleminded cannot be expected to use judgment in respect to moral acts. As a matter of fact, psychologists now recognize that the moral and ethical sense is not much developed until after twelve years of age, although no one denies that children from a very early age possess a theoretical knowledge of right and wrong. The use of the term 'right and wrong' in a legal sense is an absolute misnomer. The legal test is, therefore, absurd on the face of it, because it does not take into consideration the inability to act on a theoretical knowledge of right and wrong. It dates back to times when the mechanisms of human behavior were little understood. . . . . No court would pass upon an obscure case of bodily ailment; yet courts every day do pass judgment without hesitation upon far greater questions of mental disorder and responsibility."

[1] Indianapolis: Bobbs-Merrill Company, 1923.

How does this quotation apply to Dr. Williams' testimony in the case cited above? It proves his consistency and explains his position. He believes that the law is antiquated, yet that as long as it is the law, it should be upheld, and he answers truthfully and logically that he believes this youth knew that his overt act was wrong; as for the rest, he leaves the law to take its course.

However, other psychiatrists have another and equally sincere attitude toward the courtroom tests of insanity. Dr. William A. White, of Washington, D. C., authority on mental and nervous diseases and on the legal aspects of psychiatry and an expert witness for the defense in the Loeb-Leopold case, interprets his duty as witness under present conditions not so much in accordance with the letter as the spirit of truth. He declares:

> "However possible it may have been at one time for the medical and legal professions to come together on these tests and find in them a basis of common understanding, that day has long since passed, at least from the standpoint of the specialist in mental medicine. The standpoint from which he approaches the problem of human behavior no longer makes it possible for him to be dogmatic and categorical in his replies to the question of the lawyers on these points. . . . . The language of the law, while it might have been all right a hundred or two years ago, is no longer usable by the present-day psychiatrist who finds himself quite unequal to thinking in such terms and much less able to use them exclusively, as he is required to on the witness stand, for the expression of his thoughts. . . . . Father Schmidt [citing a notorious case in which the defendant was found sane and executed] when he murdered Annie Aumuller, may have possessed a knowledge of right and wrong in the sense that he knew it was against the law of the land to commit murder, as indicated by the fact that he tried to cover up the evidences of his act, but nevertheless at the time he drew the knife across her throat, he thought he was carrying out the command of God, he knew that he was doing right."[1]

Any number of cases might be cited, any number of textbooks on psychiatry quoted as further evidence of the professional harmony existing between alienists testifying at these trials. In Los Angeles alone, to mention a few, there is the Harry New case, when alienists on both sides, five in all, agreed that the defendant, New, was a moron, with intelligence permanently arrested at about the eleven-year level.

[1] *Insanity and the Criminal Law*, by William A. White, M.D. New York: The Macmillan Company, 1923. pp. 103 *et seq.*

Yet the defendant was convicted. Oxnam, De Witt, Bundy, Louis Fortin, Harris, the Negro, all murderers who have been recently hanged in California were declared to be mental defectives by every examining psychiatrist. Yet where insanity was plead, the whole situation changed, and the same alienists were testifying heatedly on both sides, disputing over—what? Responsibility, determinism, "free will", right, wrong, punishment—abstractions all, upon which they may render religious and ethical opinions, but in no circumstance a professional opinion. Such is the impasse into which the law has driven the medical expert. What, then, should be de-bunked? The law or the medical profession? Why has the medical expert been ridiculed and censured, and not the law?

The subject may be approached, and has, in many different ways. For a roughly outlined layman's article, such as this, it seems well to emphasize two points:

First, there is the conviction on the part of almost every man that he can tell an insane person when he sees one; that if a person is "calm" and "intelligent", he is indisputably sane. These words, "calm" and "intelligent", appear over and over again in the newspaper accounts of the kind of trial under discussion. The writer has accumulated an interesting collection of such newspaper comment and fallacious reasoning. Such reasoning is not confined to the average observer, but is shared with the so-called educators of popular opinion. There is Chester Rowell, for instance, who, not so long ago, in his syndicated column commented upon the fact that certain convicts in Folsom Prison who had engineered a prison break were about to plead insanity.

"They were, to be sure, sane enough", he argues, "to plan and lead the attempted outbreak, and dominant enough personalities to overawe their unwilling comrades, and they were clear-headed enough, when they saw they were beaten, to surrender and bargain for terms. These are all the marks, not merely of sanity, but of unusual intelligence and capacity."

Now Mr. Rowell's opinions and decisive statements are accepted with respect by thousands of readers of the daily newspapers. Yet here he makes a positive assertion upon a subject of which obviously he has no knowledge. Any quali-

fied alienist would have instructed Mr. Rowell, had he taken the trouble to inquire, that mental capacity, intelligence, and ability to carry out a preconceived plan are not conclusive proofs of a sound mind. And for Mr. Rowell to state in all seriousness that an organized jail break marks the perpetrator *ipso facto* as sane and having an extraordinary I.Q.—well, we need make no comment, for that statement is aside from our point, which is that a man of Mr. Rowell's attainments believes that he needs no expert knowledge to diagnose a case of insanity, and that insanity is a question of intelligence and mental capacity.

This statement is fallacious even when applied to the legal test of insanity, the "right-and-wrong test". Many paranoiacs have intelligence and mental capacity. So have most schizophrenics. Drs. Singer and Krohn, who testified for the prosecution in the Loeb-Leopold trial, stated, on page 57 and following of their book, *Insanity and the Law*:[1] "The intelligence of schizophrenic persons is usually good and is often above the average. Indeed, it seems probable that high-grade intelligence is necessary for the development of this mode of reaction." Further, in speaking of the deterioration that leads to these abnormal mental conditions, the authors write: "First, it should be said that the intellectual mechanism remains undamaged, though this is not always easy of demonstration."

Not to become too laboriously technical, then, it may be stated, with authorities in agreement, that the emotions bear a far greater part in the determination of one's mental state than does the intellect. But the "hard-boiled business man" previously referred to, and the intelligentsia as typified by Mr. Rowell, see the defendant sitting "calmly" and hear of the defendant acting "intelligently" and, forsooth, he is sane, and any expert who declares otherwise is either crooked or crazy himself or both. They are as sure of their infallibility on this point as were their progenitors who knew that the sun traveled round the earth because they saw it with their own eyes, and who heaped scorn and ridicule on the experts of their time.

[1] *Insanity and the Law*, by H. Douglas Singer, M.D., and William O. Krohn, M.D. Philadelphia: P. Blakiston's Son, 1924.

But there is another and more elemental reason for the unpopularity of the medical expert. The alienist testifying for the defense stands for the red rag of juridical change. The people charge it in instinctive fury, as they have always done. Gradually, at a creeping pace to be sure, but steadily, the law is wresting from them a privilege that they have always deemed a right, an important source of animal pleasure—the vicarious torture of the social outcast. The people are being divested of a once universal license, the license to give public vent to their baser emotions, their hate and lust for revenge, and yet retain their self-respect. The gradual process of this divestment is interesting to trace.

There was a time when, with pomp and circumstance, even inanimate objects were often punished. A cart wheel that had run over a man, for example, was ceremoniously destroyed in the name of the law. With the same high-minded purpose and with great dignity and formality, distinguished gentlemen in pretentious robes tried dogs or cats, and meted out due torture and punishment to such creatures, in accordance with their best and most pious judgment, while the best citizens of the time enjoyed the spectacle because "justice was being vindicated". Nor did children escape their zeal. Children were hanged, imprisoned in foul dungeons, and sent into exile; their tongues were torn out, their eyes rendered sightless. Indeed it is only within our own memory that special acts have been passed to exempt them from the rigors of the law. As for the insane, it is only comparatively recently that the defense of insanity has been admissible. Instead of mitigating punishment, a diseased mental condition often augmented it in the past, as the good people of a few hundred years ago were convinced that such unfortunates were possessed of the devil and should be crucified, boiled in oil, burned at the stake, quartered, stretched on the rack, all in the name of righteousness and justice and for the greater glory of God. Gradually, as the centuries passed, a few leaders here and there would come to view the aspect of crime and wrongdoing in a different light, and would attempt to incorporate a shade of enlightenment into the welter of ignorance and lust for revenge. They came to see the absurdity of wreaking official vengeance on a tree trunk or a chair; though even to this day

we see man returning to this infantile reaction when in a fit of rage he smashes the furniture against which perchance he has stubbed a toe. No longer are dogs and pigs tried and punished in formal courts; the impulse of the individual lord and master to "kick the cat" may still survive, but his childish atavism and sadistic tendency is no longer reflected in the law of the land. Any number of men and women are still in favor of hanging and torturing children for their misdeeds. Indeed, children are still hanged in some cases and punished by various devices with the full sanction of the law, for the law cannot move much faster than the people wills. But the theory is gradually taking a firm hold that a child is not a responsible creature and therefore should not be an object of punishment, and the child criminal is now handled through juvenile departments whose object is to protect the community and rehabilitate the youthful offender. The child has been segregated as not a proper object for the vengeance of the crowd.

Upon the same theory the law has excepted the adult insane from its magisterial vengeance. It declares that an insane person cannot be "guilty". Jurists, advanced for their time, made this declaration many years ago. "But what", was the question confronting them, the question propounded by the infuriated crowd denied their victim, "what *is* insanity? This criminal is not shrieking and raving and tearing his hair. How dare the law let him escape by calling him a lunatic! Death to him! Give us our hanging and our holiday!"

Bunglingly, out of the medieval fog of metaphysics and superstition, the advanced thinkers of their day tried to concoct a reasonable answer, a rule and principle that would apply to every case. It was not easy. A dog or a cat, a cart wheel or a tree trunk, can be identified and segregated. So can a minor for whom the law may fix an arbitrary age. But what should be the criterion for distinguishing an insane person from a sane person? What the dividing line?

The courts chewed over this problem for many years. The first definite test applied was the "wild-beast test". It flourished as late as 1723, when Mr. Justice Tracy said: "It is not every kind of frantic humor, or something unaccountable in a man's actions, that points him out to be such a mad-

man as is exempted from punishment; it must be a man totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute or wild beast; such a one is never the object of punishment."

No statistics will ever reveal how many persons of "frantic humor" and "unaccountable" actions were executed during the centuries when this doctrine prevailed. Then the legal conscience became once more active. The "wild-beast test" seemed extreme, and in 1800, Mr. Erskine, in a brilliant and eloquent defense, secured the acquittal of Hadfield for shooting at the king in Drury Lane Theater, on the ground that, being the victim of fixed insane delusions which caused him to commit the crime, the defendant was not responsible. From this time on the "knowledge test" crept in, the "right-and-wrong test". But Chief Justice Mansfield put a check on insidious advances, such as Lord Erskine's eloquence was in danger of fostering, by ruling in 1812 that "if such person were capable in other respects of distinguishing right from wrong, there was no excuse for any act of atrocity which he might commit as the result of delusion". And no statistics will reveal the number of executions that continued to occur under this "advanced" ruling. Then in 1843, in another revolutionary trial, once again the number of victims was cut down. In that year occurred the trial of McNaughton for shooting Drummond to death, whom he mistook for Sir Robert Peel. At the trial it was shown that McNaughton harbored the delusion that Sir Robert had been persecuting him, hounding him in an effort to ruin his reputation. In all other respects the defendant was apparently normal. He was acquitted. So enraged were the people that the House of Lords requested from the trial judges a statement in answer to a questionnaire, explaining in full the rules and principles whereby such a verdict could have become possible. And in their reply the trial judges formulated and established as a guide the principle that governs the courts of England and the United States to this day—namely, that to establish a defense on the ground of insanity, it must be clearly proved that at the time of committing the act, the accused was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or if

he did know it, that he did not know he was doing what was wrong.[1]

So, in excluding from the ranks of the condemned offenders who were suffering from a delusion that caused the overt act, Mr. Erskine's doctrine was reaffirmed. This was almost one hundred years ago, and since then the whole subject of psychology and psychiatry has developed from theory and specucation into a science. But the law has remained fixed.

And now revolutionary changes are brewing; psychiatrists and criminologists are proposing changes which, when echoes of them reach the public, are met with the same violent opposition that marked every advance in the past. For the modern psychiatrist and criminologist are advocating completing at one sweep the job their predecessors have been merely toying with. They would take from society's vengeance the remaining fraction of social outcasts and handle them in accordance with modern scientific methods. While the tendency has been to permit fewer and fewer scapegoats, modern science asks, Why have scapegoats at all? What real difference does it make to an offender, save in case of capital punishment, whether he is labeled "wicked" and "criminal" and punished with imprisonment in a building called a penitentiary, or labeled "good", but "insane" and corrected by confinement in a building called a hospital? In both cases he is deprived of his liberty. And what difference does it make to society? Why split legal hairs to settle this mystical question of man's goodness or badness, to pin a label on an offender, when the practical consequences are to such a degree the same, and are tending more and more to become identical? Why not make the matter of segregation the focus of the trial instead of the matter of punishment? Instead of the court bringing all the lumbering force of its expensive, top-heavy machinery to bear on the question of guilt or innocence—a procedure that, taking into consideration the frailties of all mankind, including judges and juries, is enough to make the cosmos smile—instead of thus trying to imitate Omnipotent wisdom, why not take out the old machinery and install new? Why not center the legal process around these simple, practical, yet vital questions: Is the act complained

[1] Singer and Krohn, *op. cit.*, p. 288.

of dangerous or harmful to society? Did the accused do the act? If he did, what shall be done with him in order best to conserve the individual and protect society? In short, why not treat the adult criminal as we treat inanimate objects, animals, minors, and the obviously insane—protect society, and let it go at that?

Why not? Because such sweeping reform would not be tolerated, depriving us, as it would, of the last crumbling remains of our once universal privilege—that of indulging our lust for revenge and hate. There would be nothing left then for us to punish, except perhaps our children and our dogs. We would be in peril of becoming Christians in reality, of feeling sympathy for all mankind, and gradually of understanding human motives; while at present to feel sympathy for and harbor a desire to understand abnormal behavior is considered a mark of degeneracy, a perversion that should itself be punished. We reject such reforms with all the pious claptrap and high-sounding shibboleths with which we always clothe our unlovely instincts to make them respectable. "Justice must be vindicated", we chant. "Society must be protected." "We must make examples for others." But as the occasion becomes special and our excitement is heightened, our phrases lose their dignity. Then it is, "I'd like to hang him with my own hands!" "Hanging's too good for such as he!" "I hope he'll swing for it!" "Death to him!" "Kill him!" "Burn him!" Or if a little squeamish about doing the job ourselves, we hire an executioner. Should an individual here and there suggest anything approaching a reform in this ancient, well-loved procedure, we label him a "long-haired reformer", unfit for the society of real "he men" with "red blood in their veins". Or if the dissenter is an expert expressing his findings and tracing out the mental or emotional bypaths that led the criminal to this pass, such expert is "crooked", "selling his opinions" "to save a neck that is overdue to be cracked".

It is such a short time, after all, since a hanging, quartering, stretching, or mutilating was an occasion for a public festival which all the righteous attended. And now the sight of an authorized killing is open only to a select few, has become a form of special privilege. Tickets are issued only to

men with a drag. Women are not admitted, "he men" always being tender protectors of the sensibilities of females except when they believe one of them needs hanging. Only about two hundred males, judiciously weeded out of the thousands of applicants, were honored with tickets to the William Edward Hickman function in San Quentin. All the rest of the eager public were compelled to look to the newspapers to furnish them with a kind of second-hand thrill. It is the newspapers' job to make their accounts so realistic that their voracious readers may feel as if they were actually present and taking part in the event. This they do right heartily.

Students of psychiatry, criminology, and the science of human behavior are with increasing insistence demanding something different. Jurists here and there are beginning to study these subjects with a view to applying their knowledge to the human problems with which they are confronted. It is a dangerous time for the pleasure of the mob, and this they know. And at every fresh assault of science and enlightenment upon their ancient privilege, their right to enjoy a killing without feeling any sense of sin, they meet the attack with rage and ridicule. The expert alienist, in league to rob them of their festivals of reading, if not of seeing, is naturally a highly unpopular personage. To quote again from Mrs. Lindsay's correct interpretation of the popular spirit:

> "Of course nobody can tell how a jury will decide, but it's easy to realize that people who can think even a little are disgusted with the efforts made by attorneys to get people into insane asylums when the public feels, without analyzing its sentiments, that a few hangings would do more to reduce the murder rate than anything that psychologists can devise."

"The public feels without analyzing its sentiments", writes this lady, and with this statement every psychiatrist will agree. The psychiatrist and psychologist analyze those sentiments. They are not pretty.

MIND—MAN'S MOST DISTINCTIVE ORGAN *

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IN the first chapter of *Dombey and Son,* Dickens portrays the two weightiest and most essential events in man's short span of life—namely, birth and death. While the baby, Paul, was carefully tucked up in a little basket bedstead in front of the fire, the mother, Fanny, "drifted out upon the dark and unknown sea that rolls round all the world". The reason ascribed for Fanny's exitus was her unwillingness or inability to make an effort. As the sister-in-law says to the husband, "An effort is necessary. That's all. * * * I have no doubt she'll make it. Knowing it to be required of her, as a duty, of course she'll make it. * * * If you have any reliance on my experience, Paul, you may rest assured that there is nothing wanting but an effort on Fanny's part. And that effort she must be encouraged, and really, if necessary, urged to make."

Effort, strain, energy. In such terms only are we able to feel ourselves into the processes of life and to recreate in our imagination the course of evolution that fate has decreed it should follow. Whether Fanny could have made the effort expected of her, and if she had, whether she would have lived, are for all the Fannies questions that remain unanswered. The feeling, when we have pursued one course of action, that we might have pursued another is no proof that we could have. Do we live or are we lived by a host of controlling and mostly unknown forces? This raises the whole question of freedom versus determinism. I can only answer by saying that the more profoundly we inquire into the antecedents of any given act or acts, the more surely do we find adequate explanations for such acts in terms to which, from the point of view of present-day scientific standards,

* Read before the Interstate Postgraduate Medical Association of North America, Atlanta, Georgia, October 16, 1928.

we may properly apply the term cause. If this were not so in the mental realm, as it is in all others, then so far as I can see any inquiry would be a more or less useless and meaningless occupation.

This effort, strain, tendency, drive, call it what you will, is what we know as function, for we can think of function only in terms of effort. In the physiological realm we are accustomed to see this function stored, sluiced, channeled, and distributed to the ultimate consumer by means of a series of structures which exist for that purpose—blood vessels; lymphatics and their contents, blood and lymph, as carriers; nerves and nerve fibers; and many others. With the mind it seems different, for here are no tangible parts to deal with, but only what appears to be nascent function. Many would insist that the brain is the physical organ of which the mind is the function. While I am willing to admit that the mind manifests itself through and by means of the brain, I do not think such a statement—namely, that it is the organ of the mind in an exclusive sense—can be true. The heart may go on beating when removed from the body, but we have no evidence that a brain removed from the body could be the seat of mental functions, more particularly of consciousness.

Approach the problem as we will, from the standpoint of what we know or from the standpoint of what we do not know, the only practical thing to do is to consider the mind as such, irrespective of its relation to any structure, or structures, as a legitimate subject of inquiry. There are those who insist that mind and cerebral cortex should not be separated, but that all mental phenomena should be translated into the language of neurology. This to my mind is not only a bootless procedure, but an altogether foolish one. While I have every sympathy with all attempts to bring about a correlation between mind function and cortex function, I see no reason why we should stand idly by waiting for the day of its consummation before we proceed with our investigation of the mind. The outlining of the natural history of a function is as worthy an enterprise as recording the natural history of a structure, and in these days, when modern physics seems even to be repudiating matter, the distinction seems to be one that presents few real differences. Talking about

mind in terms of nerve cells does not help us understand it. It only translates the language of psychology into that of neurology, and to my mind with no gain. To this linguistic device, which seems to me only another way of retaining the cerebral mythology of the last century, Professor Meyer has given the very expressive designation of "neurologizing tautology". What we may do if we wish—and what I do, as a matter of fact—is to consider by analogy the mind as an organ, in the sense of any other organ—namely, that it has something to do; in which case, by further analogy, its content would be its structure and its processes its functions. Considered in this way, I am justified in my title: *Mind—Man's Most Distinctive Organ.*

What are some of the distinctive characteristics, some of the outstanding facts of structure and function, of this organ of the mind that grow out of this way of considering it and that have importance and significance for medicine? Naturally I can only touch upon a certain few points lightly.

In the first place, the organism as a whole, to use the modern biological term of expression, is like a many-faced crystal. Any one of its many facets may be examined to the exclusion of the others, and in that facet the examiner will see his own particular interests reflected. The anatomist will see structure; the chemist, molecules, atoms, radicles, valencies; the physiologist, organ functions; the drug therapist, pharmaco-dynamic reactions; the surgeon, the answer to his question, Shall I operate? The psychologist will see mind, and the anthropologist will see a functioning unit in a large racial scheme with customs, traditions, and a culture. But please note that the fact that one may be interested in only one particular facet does not mean that the other facets do not exist. Quite the contrary, and it is my main thesis that the neglect of the psychological facet has reached a stage, not only in medicine, but in the social sciences generally, that calls for prompt and decisive recognition and appropriate action if we are to be saved from the serious consequences of our failure.

The reason for this failure seems to me to reside, in part at least, in the exceedingly simplistic, not to say naïve, way in which the mind is usually thought of, and consequently

the almost complete helplessness the average person feels if called upon to observe and describe a person's mental condition. This type of reaction is often seen on the witness stand. Why people should have this sort of attitude toward the mind, which in the next breath they will declare their most valued possession, is not easy to see, and I will not discuss it further. The fact is, however, as is implied in my analogy to the crystal, not only that the mind is as old as the body, that every state of the organism has a mental as well as a somatic aspect, but that the mind is quite as complex, if not more so, than the body, and that it has embedded in its structure, just as has the body, the evidences of its historic past.

We have been familiar with such facts as these in every other realm than that of mind for so long that it seems it should be easy to accept them in this realm when attention is called to them, but experience has proved that it is not. However, a few analogies and parallels will help. In the field of neuro-anatomy, we have for some time recognized old and new parts of certain organs. Thus we speak of the paleo- and the neo-cerebellum, the paleo- and neo-striatum, the paleo- and neo-thalamus, and the archi- and neo-pallium. It is not to be supposed that the newer structures have taken the place of the older ones; they have merely supplemented them, and the older ones continue to function under the newer arrangements. For example, I saw a patient a few weeks ago with incipient signs of paralysis agitans. There was a slight tremor in one hand. When, however, this patient was asked to walk across the room, the whole arm was kept close to the side and did not swing as did the other. In other words, he had lost a component of what is normally left over to us of our quadrupedal gait. Surely that is not difficult to see or to understand in the light of the pathology of this affliction. Why should it be more difficult to understand, when a patient tells you she is afraid to hate any one, for, when she does, something terrible happens to him, that she is using a method of thinking common to both child and savage, based upon the idea that events can be brought to pass by thinking them; or that our common term "fourscore" contains within itself

the remnants of that historical past when savages counted by fingers and toes, and is our present way of saying what he would have expressed by "two hands and two feet" or "one man".

I have used this illustration of the historical content of the word "fourscore" because I wish to emphasize that it is by the same methods by which we arrived at its meaning that we arrive at the meaning of mental reactions. We cannot interrogate the mind by the questionnaire method and expect to get very far. The important meanings lie deeply buried in what the psychoanalysts call the unconscious, and they are for the most part incapable of expression in our usual, everyday language. Psychiatry deals with the irrational or non-rational components of the mind—those that are more nearly of pure feeling value. We have been too long fooled by the delusion of man's rational superiority. The significance of the irrational factors is tremendous, and only in this century have they received any adequate recognition.

To illustrate, consider for a moment that ancient part of the cortex known as the archi-pallium, which is, as you know, the olfactory cortex. If I turn to an authoritative work on neuro-anatomy and physiology, I find the statement that in man the sense of smell has practically disappeared and that therefore the olfactory connections are of little importance. As well might one say that counting by fingers and toes has disappeared, but we find its impress in the English "fourscore" and again stamped into the very pattern of the French system of enumeration in *quatre-vingt*. I cannot but recall my teacher of brain anatomy, who was rather inclined to think that the cerebral hemispheres might be considered as outgrowths of the olfactory bulbs. Just as the quadrupedal component of our gait might have had to wait to be picked out and emphasized by some disease before it was recognized, so it may be the same with our olfactory sense. I am thinking of the possible significance of the olfactory aura in epilepsy, and similar phenomena in uncinate fits. In the meantime I am wondering if smell is really so unimportant as our neurological friends seem to think (apart from the fact that a very considerable number of peoples do not shake

hands or kiss when they meet, but smell each other, while as for the organ of smell, the nose, it is sufficient to recall Pascal's remark to the effect that if Cleopatra's nose had been a trifle longer, the whole political geography of our planet might have followed a different course).

Of the importance of odors, the national bill for perfumes would give some vague idea. No doubt, however, vision and hearing have very largely superseded smell, taste, and touch, yet, as before, that does not mean that these senses no longer exist. I am sure they do in many important and intimate aspects of life, and that in the field where they function most, they are less properly the subject of conversation; they have been largely repressed— they will be found in the unconscious.

This unconscious, this repository of our historic past, contains an enormous fund of energy for good and for evil, for from it comes the motive force of our conduct, which, meeting similar or different motives from others and the natural objects of the environment, is molded into those structures, mental and cultural, by which we know man and his civilization. It is this clash of motives between the old and the new, between different individuals, between the individual and the environment other than personal, that gives origin to intrapsychic tensions as the prompt flow of energy from perception or from desire into action is interfered with more or less, and it is the prime function of the psychic apparatus to resolve these tensions. This may, perhaps, be the most general expression of the function of any organ of the body. Nevertheless, the mind is not ordinarily thought of in such terms and thinking of it so is, I am sure, enormously clarifying.

Let us come at another aspect of our subject. It is gradually getting to be a part of medical thought that there is no real distinction between the normal and the abnormal, quite as you may have already inferred that I think that our separation into mind and body is purely artificial and solely for convenience sake. The chemistry of a disordered metabolism is not a different chemistry from that taught in the academic department. The elements will be found to have the same valencies. Just, therefore, as we may properly interrogate a particular organ or function as to its meaning, usefulness,

or purpose in the general scheme, so we may likewise interrogate a disease. We have long known that certain manifestations of disease, such as fever and leucocytosis, were useful, but that is very different from saying that the disease itself, such as typhoid fever, is useful. You will recall that one of the implications of Stockard's experiments with alcohol on the progeny of rats was that constant exposure killed off the weaklings and that the result was a more robust strain. Perhaps exposure to various lethal agents is one of the ways of building up a strong and capable race of men. However that may be, it is not easy to see the value of typhoid fever in the abstract; perhaps we might see its usefulness in a particular case. Whatever the case may be with typhoid fever, I often wonder whether all the knowledge of the hereditarians and the eugenists could sterilize more wisely than the gonococcus.

A more concrete example will bring us to closer grips with the question. I knew at one time a very prominent man who always impressed me as being inherently one of the most timid persons I had ever known. In fact, he impressed me as being actually frightened much of the time or at the slightest reverse. He occupied a powerful position and was known as a most astute manipulator of men and of situations. It seems to me that it is easy to see how fear had made of him a diplomat in his dealings with men. Assuming that his fear was the expression of an anxiety neurosis, then the meaning and purpose of his anxiety can be seen. It was through his powers of diplomacy that he came into prominence. It seems to me, too, that it is not so difficult to understand why this man died of diabetes mellitus. We know enough about the mobilization of sugar to see the connection. Now if we interrogate the diabetes and ask its purpose, the answer is that it was the final stage in an effort at a physiological response to the demands of his anxiety. And finally, when this man died, it was discovered that he had infantile genitalia. Is not this picture of constitution, success by psychological over-compensation, disease resulting from a breakdown of the compensatory mechanisms, and death, a consistent whole? Do not all the parts fit? And do

you not see what I mean by a psychological component of physical disease, and the purpose of disease?

This organ of the mind must be consulted much more frequently than it has been in the past. It will be found to have important contributions to all problems of human origin or interest. Let us consider briefly one or two. I can remember, when I was studying medicine, that if we made a diagnosis of diphtheria, and the patient did not die, we concluded that we had made a mistake. Such was the rigidity of our concepts in those days. We are confronted by a like rigidity of concept in those instances in this country in which an attempt has been made to combat the so-called "crime wave" by increasing the severity of punishment. These attempts are just as ludicrous to the psychiatrist as would be an effort to handle the whole public-health problem of typhoid fever in a community by attempting to reduce the temperature of the individual patients. As the old insane asylum has gradually evolved into the mental hospital, so prisons need to evolve into laboratories for the study of human conduct and the possibilities of its modification along socially useful lines. Hear what Professor Liepmann has to say:

"America might well imitate Germany in its battle against a rising tide of crime, not the Germany of the classical school of penal law, but post-war Germany. The seeds of delinquency and criminality seemed to be powerfully and hopelessly rooted in the period after the last war, the period of the revolution, the inflation, and the economic crisis. But we have not taken up the battle against them by increasing the severity of punishments. We did not follow the advice of those who recommended that we remove a serious natural disease by external radical cures. On the contrary we have, by preventive measures, fought unemployment and juvenile delinquency from the inside.

"During the periods of the greatest criminality, we tried to decrease the importance and power of imprisonment, to free penal treatment from all superfluous and harmful severity and give it an educational value. The result of this work has been a reduction in crime. There is no better example of the utility of the modern school of penal law, no better evidence for the harmfulness of the arguments in favor of

harsh punishments. In America, however, the wrong road has been followed and reliance placed on the electric chair and on pitiless severity. With this, the 'crime wave' and the fear of it have gone hand in hand. It has failed to master the increase in crime."[1]

Then there is another problem of prime importance for the period of civilization we are just entering—the flying age. The psychological component of the problem of flying has been recognized by the assignment of flight surgeons to the various air-service units of the military establishment. As yet, however, outside of certain physiological standards and rather vague notions of temperament, we know very little, and yet we are moving headlong into a period when almost every one will be flying or, as a passenger, will be dependent for his safety upon the ability and skill of a pilot, as we are to-day upon engineers and ships' captains. Two avenues of approach to this problem suggest themselves which, so far as I know, have not as yet received any real recognition. The first is to subject to the most careful psychological examinations possible every pilot who crashes and is not killed, with a view to finding out the psychological factors that preceded and entered into the accident. The second is to examine with the same meticulous care the various superstitions, taboos, hunches, habits, and so forth, of the several members of the air corps, to see upon what they depend and what, if any, part they play in the pilot's performance. There is ample room here for an intensive bit of research work which I am convinced needs to be conducted along psychoanalytic lines.

As regards flyers' superstitions, it seems perfectly obvious that if a given pilot had a peculiarly strong aversion to Friday and to thirteen and had for any reason to fly on Friday the thirteenth, such a necessity might easily condition an emotional imbalance that might account for an error of judgment at a critical time. I remember a boy who had the delusion that a spirit inhabited his thumb. Without entering into the cause for this belief, it is obvious that if he should happen to hit his thumb with a tack hammer, the

[1] *Mental Hygiene Bulletin*, Vol. 6, p. 2, June, 1928.

traumatism would have a much deeper significance than for the average person.

And finally there is the much overworked concept of heredity. Just a word about it and incidentally about another very important matter—namely, culture. The doctor has all too often considered the human individual, his patient, as a unit distinct from every other individual, as a closed system separate from his environment. Of course, such a concept is 100 per cent wrong. The noted biologist, Professor Jennings, goes so far as to say, "Possibly we should be better off with no such concept as heredity; then analysis would be correctly directed toward understanding, in organisms as in other things, in what ways there is dependence on the stuff they are made of: in what ways on the conditions in which that stuff is found." However that may be, we are altogether too glib in attributing all sorts of things to heredity. In regard to psychological characteristics especially we forget that marvelous structure that Herbert Spencer used to call super-organic—namely, culture. Culture is a structure that is built by man little by little, each generation contributing its mite, but that nevertheless has a certain very real independence of any particular man and to a less degree of any group or generation. It is a sort of repository of the successful beliefs and customs that man has come at in his tedious journey and, as an independent structure, it influences all because we are born in it and of it and it is thus a carrier forward of the past quite as truly as the germ plasm. The fact that Mary Smith has the same illness as her mother may no more be dependent upon heredity than that you and I both speak English.

It is necessary that we, the doctors, should treat man not only with a full recognition that he has a mind, but also with an equal recognition of the fact that he is a social animal and that all disease has not only psychological, but social aspects.

You are all fully aware of the enormous social significance of pulmonary tuberculosis, of the venereal diseases, of the cardiopathies, and of cancer, but did you never see a man go down and out while the doctors subjected him to all manner of examinations and found nothing? Such a result comes

from the complete frustration of an individual and was a common occurrence in prisons where the rule of silence and solitary confinement prevailed. The prisoner finally broke under such a régime. Such a frustrating effect can be wrought by a dominating personality, and one occasionally sees such a situation. The emotional stresses become more and more severe until finally something must give way. On the other hand, one also sees miracles wrought by the beneficent influence of a loved person. It is within the field of operations of such forces, which for all I know may have potentialities as great as the unleashed forces of the atoms that the physicists talk about, that the physician works. It is a charmed circle, but the way about it is a complex maze in which we are apt to be lost. But the principles involved are not hard to understand. The patient is the center of all sorts of cross currents of emotional influence from the members of his family, from the doctor, and from the nurses. The practice of medicine must learn how to guide the patient through this maze and how to utilize the forces in this field of operations to his advantage.

All these reactions I have discussed are distinctly human, all too human, reactions of that most distinctive of man's organs, his mind. They span the distance from simple reflex all the way to the complex institutions, financial, judicial, scientific, spiritual, of his civilization. As Dewey says: "We must conceive the world in terms that make it possible for devotion, piety, love, beauty, and mystery to be as real as anything else." Is it possible that we can longer disregard these supremely important and significant qualities of man when we come to treat him as a patient?

PSYCHIATRIC METHODS AND TECHNIQUE FOR MEETING MENTAL-HYGIENE PROBLEMS IN CHILDREN OF PRE-SCHOOL AGE *

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IN broad definition, the mental-hygiene problems of the pre-school age are not particularly different from those of any other age group. Two general types of mental-hygiene problems may be recognized: (1) those in which failures in development or in social adaptation are dependent upon distinct types of mental disorders (for example, feebleminded-ness, epilepsy, and organic reductions in reactive or inhibitory capacities such as occur with epidemic encephalitis) and (2) those in which behavior occurs that in one way or another disturbs the people with whom the child lives so that they recognize him as a problem. In general, recognition of the latter group depends upon the fact that some item in behavior disturbs the peace, comfort, or pride of the parents. Some of these situations are unquestionably very serious, but there are other equally serious problems, particularly in the personality field, that are ordinarily passed over by the parent as being of no importance. This is especially true of the very quiet, submissive, extremely "good" child who gives his parents no worry and concern. Nevertheless, this personality mechanism is pernicious because the child comes to live in an inner world from which reality and socializing contact are to a large extent eliminated, and the results of this may, in the end, be very serious.

While any discussion of mental-hygiene problems in children of the pre-school age should logically include problems

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of the first type, they will be disregarded except for this one short paragraph. The psychiatric problem in these cases lies in recognizing the condition, and after the diagnosis has been made, in seeing that proper treatment and proper education are provided and in working with the parents to induce them to accept the limitations imposed by the conditions in question and to prepare them to deal intelligently with the situation over a long period of time. There is no question but that the way in which these children are managed may have a powerful effect in determining their behavior in given situations. Hence the need for work with the parents, the provision of special kinds of education, and the like. Methods of handling these problems, however, are by now pretty well standardized, and varied social machinery is in existence for dealing with them.

We turn, then, to the second group, in which there are four major types of problems to be considered. The first of these is habit formation, particularly those habits that in one way or another are distressing to others. Here would be included thumb sucking, enuresis beyond the usual age, temper tantrums, finicky food habits, sleep disturbances, speech disturbances, nail biting, masturbation (an activity which is, I think, improperly called masturbation is very common in children of the pre-school age), stubbornness or negativism (a common type of faulty habit formation), and oversubmissiveness.

The second major group includes personality reactions, chiefly in the form of emotional reactions manifested in such degree that they may be regarded as excessive. Here we place seclusiveness, timidity, sensitiveness, fears, excessive imagination, fanciful lying, excessive unhappiness and crying, selfishness, restlessness and overactivity, sullenness, revengefulness, excessive irritability (not in the form of temper tantrums), and the like.

The third group comprises difficulties in social relationships, such as fighting, teasing, bullying, impudence, disobedience, show-off behavior, lying, stealing, cruelty, inability to get along with other children, and unpopularity. All these are traits of behavior that the pre-school child, as well as the older child, frequently shows.

The fourth group of problems lies in the field of the develop-

ment of the emotions and their integration in personality, since disturbances in the ordinary development of emotional reactions have a profound influence upon the future success and happiness of the individual.

PREVENTIVE WORK

The ends for which we strive seem to be the success and happiness of the individual now and in the future. Without going into any very great detail, it might be pointed out that the word "success" implies the establishment and maintenance of satisfactory social, economic, and vocational adjustments—that is, satisfying to the individual and not in conflict with the social order. By the word "happiness" is implied a type of life that permits the individual the greatest feeling of security and joy of living and the maintenance of stable conditions of mental and physical health. Since success in relationships with others and the social order at large may enter very definitely into the problem of the securing of personal happiness, the two things seem to be inextricably linked. There is no utopian idea here. The individual can realize success only within the limitations imposed upon him by his innate make-up and the kind of training and life experiences that he encounters. There is no belief that the same kind of success is possible or desirable for different individuals. It is recognized that people find and express happiness in different ways. Perhaps all of this could be expressed by saying that what we are striving for is an individual so well-adjusted personally, socially, and vocationally that he may achieve the greatest success and happiness of which he is capable.

Much has been said and written about the problem of training people for parenthood. Much of it, as emphasized at length elsewhere, proceeds on the basis of making certain sorts of factual studies concerning intellectual and other processes and presenting this material to parents from the standpoint of sheer intelligence as what they ought to do. This seems a most inadequate kind of program. The relationships that exist between child and parent are, after all, primarily emotional, and it is only when we get past these very strong and deep emotional bonds that we come to a point where intelligence partly enters into the situation.

My own idea of parent training can be relatively briefly expressed. We have, first of all, to make people conscious of the emotional bonds that exist between them and their children and of some of the defects in their own emotional reactions toward the children. Once this has been done, intelligence may be turned upon the problem, but until the limitations imposed in one way or another upon the child by the parents are recognized by the latter in terms of their own emotional rejections or fixations, the chance of securing a satisfactory kind of handling is, practically speaking, nil.

The major need, so far as the parent-child relationship is concerned, remains, as always, that the parent shall actually have affection for the child and express it in ways that the child will understand, at the same time viewing the activities of the child with a sense of humor and a certain detached intelligence which helps to make of the child a free agent, although with satisfactory types of emotional bonds.

A second major type of effort in the preventive program is that there be adequate provision for meeting the needs of the child's developing intelligence, emotions, and physique. We deal here with such problems as the proper kind and amount of recreation, and of contacts with adults and children other than those in the family; the wise and unobtrusive surveillance of the child's activities so that they do not become dangerous to himself or too disturbing to others; recognition of the point that play is the child's work and that the doing of things—whether these be abstract or concrete, but particularly the development of the large muscle masses—provides the best kind of training. Through all this there must be a recognition of the child's interests and the satisfactions that the child obtains from various sorts of activities, rather than an imposition by the parent or teacher of things that would satisfy and interest these adults, but that have no necessary relationships with the child's interests and satisfactions.

Even the general statement of such a program is not easy and to lay it out in detail becomes almost impossible because of the variations in children's interests and satisfactions. Nevertheless, approaches can be and have been made, in the nursery school and elsewhere, to the development of various forms of recreation and useful activity. In any program one

should never make the mistake of destroying pleasure in useful activity by thinking of it as "unpleasant work".

In all of life, and particularly during this first period, responses are constantly being conditioned by the association of chance events at the time of the response. Hence always the need for careful study of the meaning of any type of behavior. In fact the fundamental question to be asked about any behavior—whether it be regarded as healthy or unhealthy, normal or abnormal—is: What is the meaning of this behavior? What need or urge does it satisfy in the child? Has it any possible future unpleasant significance? Only by answering these questions can we determine whether a given bit of behavior is to be encouraged or discouraged. The most important element in the preventive program has to do with parents, their attitudes and relationships with their children. I think it is fair to say, so far as behavior in terms of social relationships goes, that the parents are the most important elements in its construction.

TREATMENT OF DEVELOPED PROBLEMS

A reconstructive program hinges around the treatment of the behavior and personality difficulties that may arise in the child. The first element in any such program is the proper diagnosis of the causes of the behavior. The experience of the last few years has taught us a great deal. It is not enough merely to study the child as a physical or mental organism and to make a diagnosis of his difficulties phrased in ordinary psychiatric or physical terms. To be sure, we must know the whole organism as completely as possible from both the physical and the mental standpoints. When we do so know the individual, we become increasingly aware of the fact that there are many parts of the organism that may go astray and that we cannot lump all of these possible changes into some single convenient pigeonhole. Furthermore, we recognize the fact that the individual cannot be separated from his environment. He is constantly receiving stimuli from the environment and is constantly reacting to them. Not only that, but the organism is constantly making its impression upon the environment and so modifying the reactions and stimuli coming therefrom. We have, therefore, to study the entire situa-

tion—the individual and all of the things to which he reacts. The most important elements in the environment are precisely those dynamic elements—the persons—and their reactions and behavior to which the child must react in one or another way.

Aside from the study of the dynamic ways in which the organism reacts, we must recognize that there are limitations in the individual, in his capacities to respond. Not only is this in general a philosophically true statement, but there are many particular ways in which the organism may be limited, as in the case of intellectual inferiority, physical inferiority, some chronic types of disease, and the like. In determining, then, the possibilities of a treatment program, these factors that limit the capacity of the individual to respond must be well known and completely evaluated in terms of their present and future significance.

Diagnosis, then, becomes a matter of study of the people with whom the child lives, of his relationships to them, of his relationships to other people and to all types of tasks he may have to face, and of himself as a physical, intellectual, and emotional organism. Only on such a well-rounded study is there a possibility of erecting an adequate program for treatment.

When we come to treatment, we have to recognize that there are two major points to which our treatment program will be directed. There is, first of all, the child himself. Here a great many different methods have been worked out. A brief resumé of some of these follows.

What may well be called the Adlerian method depends upon the recognition of various mechanisms that produce feelings of inferiority and compensatory behavior in the attempt to dominate a given situation. The chief element in this method of treatment appears to be giving to the child a sense of his own importance and worth-whileness and at the same time bringing him into contact with an individual who is sympathetic and who expects from him the best in the way of behavior. In certain of Adler's work—as, for example, work carried on in the public schools in Vienna—not only the influence of the teacher, but the influence of the group of pupils who are in the class is brought to bear on these problems of behavior. One of the most dramatic experiences I have ever

had was sitting through a session in which thirteen-year-old boys were discussing the behavior of themselves and other people, explaining it in psychological terms and setting up ways in which it could be modified so that it would be socially acceptable and at the same time personally satisfying.[1]

Psychoanalytic methods have been used. To some extent, in the interpretation and treatment of every behavior problem, the knowledge of mental mechanisms gained from psychoanalysis is of importance in understanding what is going on. On the other hand, as a therapeutic technique, psychoanalysis is applicable to only a limited group of cases, primarily in older children than the age we are discussing and then on the basis of a definite symptomatology for which psychoanalysis is the indicated method of attack, whether the symptoms occur in children or in adults. Thus hysteria, or hysterical symptoms, would lead to the use of such therapy.[2]

Another method very commonly used, though considerably less in this country than abroad, is what might be called the "staged show". Here the child is brought to the doctor in front of a small or large audience, usually including one or both parents and other members of the family if they are available, visiting physicians, medical students, and other people who are interested in the clinic. The child's behavior is gone over in detail in front of him, and often some sort of explanation is given of what the behavior means. The type of explanation and its adequacy will be determined by the type of psychiatry that the examining physician is capable of using. Thus, in France, problems in behavior are explained by the psychiatrists in terms of constitutional limiting factors, which indicate that the child could react in no other way. More or less of a lecture may be given to the child. Or, on the other hand, a very sympathetic approach may be made to his problem. At times, group of cases that present similar problems are brought together and set to working out their problems in competition. In any case, the method seems not to allow for certain factors of shame, feelings of disgrace, feelings of

[1] Cf. *The Practice and Theory of Individual Psychology*, by Alfred Adler. New York: Harcourt, Brace, and Company, 1924. pp. 59–77, 339–50.

[2] Cf. *The Technique of Child Analysis*, by Anna Freud. New York: Nervous and Mental Disease Publishing Company, 1928.

being lectured, and the like, which, to judge from our own experience, must be avoided if we are to secure the best results.

Many cases present some type of problem in physical therapy, and wherever this is true, the therapy should certainly be given. There are times, however, when it is assumed that the physical therapeutic problem alone accounts for the behavior difficulties. We have never yet seen a case in which there was not also some psychological mechanism connected with the physical difficulties. In fact, physical difficulties operate chiefly, so far as behavior is concerned, by determining (1) certain limitations in capacity to react which (2) lead to oversolicitude on the part of the parents and the development of a pernicious situation in which the child is the center of attention, and (3) certain conflicts over differences between the activities permitted the child and those in which other children may engage. In our experience the latter two mechanisms are by all odds the most important and they must be met as well as the physical problem.

Some methods are described as methods of persuasion and direct contact. I would point out that in general whatever effects are achieved in direct contact with the child are in direct proportion to the emotional rapport between the psychiatrist and the individual. This emotional rapport has been called by the psychoanalyst the "transfer". What it seems to amount to in the case of children is something like this: The therapist becomes a kind of ideal or the repository of ideals which the child hopes to reach. From the emotional standpoint the child's satisfaction is achieved by inducing emotional responses in this individual (father or mother substitute). This is true no matter which of the methods previously described may be under discussion. The Adlerian method depends definitely upon the development of the transfer and the setting up in the child's emotional life of a satisfactory emotional relationship with the therapist. In fact, Aichhorn, one of the leading Austrians, describes his method of dealing with behavior problems in children as one of attempting to understand intuitively what is going on and then making a conscious use of the transfer in treatment.

To this developed emotional transfer situation must be

added an intellectual approach to the problem as well. This intellectual approach involves analyzing the meaning of the child's behavior, what satisfaction it is striving for, and evolving, either with the child or otherwise, other more acceptable means of reacting which will still permit the attainment of emotional satisfaction. With older children, this analysis is often made directly with the child, throwing the responsibility back upon him once he has clearly understood the real meaning of his behavior (I do not need to emphasize that I use "analysis" here in the ordinary sense and not in the sense of psychoanalysis).

In all the cases of behavior disturbances with which we have dealt, we have found that the problem could not be solved and treatment be finally satisfactory without taking into consideration the problems in the environment which in one or another way, usually as stimuli, are related to the behavior shown. This "indirect" approach to the problems of the child should never be neglected in the treatment of any situation, no matter how much direct work may be done.

SOME HOME PROBLEMS

In the pre-school age we are dealing primarily with the problems of the home. Many points arise. The attitude of the parents toward their children and expectations for them; the parents' ideas of discipline; their knowledge of what to expect of a child at given ages; the ambitions they have which lead them to push the child in one or another direction; their attitudes toward their own childhood experiences and their attempts to eliminate or correct the unpleasant ones in the lives of their children; the emotional bond between the parents; their emotional reactions toward the children in terms of their love, pride, and so forth; the fixation of one of the parents upon the child as a love object in substitution for some other love object which has been unsatisfactory; their attempts to revenge themselves upon the child for frustrations in their own lives which they cannot otherwise manage; and so on through a long list of emotionally determined attitudes which may be extremely upsetting in the evolution of the child's patterns of behavior.

There is also the question of the routine of the household;

its system or lack of it; the kind of training to which the child is exposed; the sort of things that he is permitted or encouraged to do and the possible future difficulties that these activities may produce. Many parents, for example, will permit certain sorts of activity while the child is small and then be tremendously upset by the same kinds of activity when the child is older.

It is certain that those in the front-line trenches can rarely have a clear idea of the whole battle. So it is with parents in their relationships with each other and with their children. Being deeply engaged emotionally in one or another way, it is very difficult for them to make a clean-cut, objective analysis of the situation, and it is often extraordinarily difficult for them to change their ways or methods, unless guided from the outside. Hence the development of a series of extra-home facilities for dealing with behavior problems.

For this there are certain other reasons also. The smaller size of the modern home; the grouping together in smaller areas of larger and larger masses of people; the assumption by agencies outside the home of the major tasks of producing and distributing the things that are needed to maintain the individual physically; the going out of mothers to work; the increasing emphasis on money as a medium of exchange; the isolation of the family from its own larger family group—all these have contributed to an increasing need for extra-home facilities. So we have the nursery school; the development of small groups of children who live and play together during certain sections of the day; the development of systematized recreation; and various kinds of clinics for studying the physical and mental problems of children. The latter clinics, whether called habit clinics, child-guidance clinics, psychiatric clinics, or whatever, are all concerned with the study of the whole individual and his situation, and it is only through this, and then through well-defined efforts to utilize the social machinery available and to change the existing patterns and attitudes in homes, that we may hope to deal with the problems of childhood in such a way that the behavior difficulties and mental difficulties of later ages may be prevented.

PERSONAL FACTORS IN RELATION TO THE HEALTH OF THE INDIVIDUAL WORKER

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IN medicine, of recent years, emphasis has been laid on the personality of the patient and on the situation in life that he has to meet; attention is no longer almost exclusively concentrated upon the impersonal processes of disease, upon questions of infection, and upon the disordered chemical activity of the system. Too exclusive reference to the impersonal processes of disease had led to the temporary neglect of other important factors. Renewed attention is being paid to the fact that even simple physical symptoms may turn out to be the expression of emotional tension in the patient's life, and that we can neither understand nor treat the symptoms adequately unless we understand and treat the patient himself and perhaps modify the situation to which he has to react. The same tendency which has led to the broader conception of health, and which has shown that one cannot, with impunity, fail to take into consideration the complexity of human nature even when dealing with physical symptoms, has received a much wider application than merely in the medical field. In education it is more and more realized that retardation in school, lack of concentration or of docility, waywardness of behavior, and the like, are not merely pedagogic or school symptoms, to be treated according to the traditional methods; they are symptoms which perhaps can be understood only when we study the whole child and scrutinize the atmosphere of the schoolroom, of the playground, and of the home.

In another field of human adaptation the same principle is being slowly established; in dealing with delinquents or criminals the tendency is not to be content with treating the delinquent act merely by the application of traditional methods, but rather to study the individual delinquent and the

situation to which he has responded and to consider the best procedure in the individual case.

A review of man's activities in modern biography and history shows that the tendency is not to deal with merely external happenings and to describe and classify them under familiar and somewhat threadbare terms, but rather to trace events to the basal forces of human nature and to show how actual occurrences are related to the fundamental human needs and urges of individuals and of groups.

A great deal of the stimulus to this work has come from the therapeutic study of individual patients with nervous disorders, and the light thrown upon the mechanisms of human nature by such study has raised important questions as to the possible prevention of much maladaptation. Hygiene is being more adequately conceived and is beginning to include preventive work in relation to a great variety of later maladaptations. The hygiene of the school child is no longer adequately represented by attention to his nutrition, to his teeth and tonsils, but includes cognizance of his habits, his emotions, his personal relationships. The teaching profession is on the alert for all new information related to this field.

In industry, too, the emphasis on the personal note, on the emotional and instinctive factors at the basis of behavior, on components of the human machine which are not related merely to special technical skill, is becoming more obvious. Industry, enterprising, aggressive, and always on the alert, wishes to know what information is available that can be utilized to meet its special needs. The more definite and precisely formulated the information, the more acceptable will it be. Where the information points clearly to any special change in procedure or to well-organized activity, the more likely is it to be received with gratitude. It is here, perhaps, that the optimistic and the over-eager and the impatient will be sadly disappointed, for the available information is, after all, somewhat fragmentary. It covers a wide field which touches large issues; it is not easy to reduce it to a simple and easily grasped summary of facts. The direction in which these facts point, the suggestions that they give as to modification of existing organizations, may

also be rather uncertain and may not always be interpreted in the same way by different individuals. In view of the comparative novelty of this body of knowledge with regard to human nature, its underlying mechanisms, its special adaptations, in view of the limited information and the uncertain application of it, many who are interested in industrial affairs may stand aloof, indifferent, somewhat distrustful, and even those who are receptive may feel rather defrauded when, instead of a prescription, they are offered only a point of view.

At the present time those who are working in the medical field feel that the point of view and the methods there utilized have a much wider application than merely in the treatment and prevention of what is usually referred to as sickness. They feel that the same methods and results can be applied to wider fields of human endeavor, and while continuing their researches in the medical field, they respectfully put at the disposal of other groups the data that they have accumulated. It is for those in the other fields, of course, to determine what facts thus obtained are of value to them in their special field, whether it be the field of education, of jurisprudence, or of industry. The present paper attempts to present this point of view to those who are interested in the industrial field and to show by a few examples that the factors which the physician comes upon in meeting the demand of a patient for the alleviation of symptoms are factors that may be of interest to the industrial expert who is studying the behavior of workers — their efficiency, their contentment, their mutual adaptability, their acceptance of discipline, their self-confidence, their initiative.

A senior executive in an industrial company consulted a physician because he was sleepless and was worried over some disturbing sensations in his tongue. The physician found no local condition in the tongue to justify the slightest uneasiness on this score. The unnecessary worry over the trifling symptoms and the sleeplessness were found to be related to emotional tension in the patient's life, to rather special preoccupations, and to a rather eager straining after high attainments. From the point of view of the alleviation of symptoms, the treatment indicated was to give the patient

an opportunity for relief of the emotional tension by a systematic review of his personality with its underlying needs and tensions. In social life this man had an urge to be an active leader in church work. In the industrial sphere the same urge led him to be active in giving advice both on technical and ethical questions. His inability to get other workers to handle their problems in the way in which he thought right was a source of worry and annoyance to him.

In this example we have a man with certain symptoms, who is, therefore, a health problem in the current sense of the term health, but the limited health problem is only one small outcropping of the problems involved in the personality of this man. The same problems also crop out in his attitude toward the workers in his own organization. The undue seriousness and intensity of his life—the patient, an earnest and high-minded man, had never learned to play—were in part determined by the home situation. He had a very conventional wife and their relations were largely determined by a puritanical outlook which was common to both and which interfered with a completely satisfactory personal hygiene. The wife found her outlet in social activities; the patient's surplus energy and nervous tension overflowed into the business field.

While these data were revealed in the course of an examination that had been made because of physical symptoms, one can easily conceive that in the industrial setting there might have arisen difficulties based on exactly the same factors. If such business difficulties are to be dealt with adequately, perhaps one may have to realize that they are the expression of underlying factors, and that the most satisfactory solution of the situation can be found only when these personal factors have been dealt with. The special characteristics of the patient which seem to be a reaction to underlying difficulties may, within limits, be an asset, and beyond these limits a liability. His eager initiative, his high standards, his missionary enthusiasm might be a source of inspiration to his organization. On the other hand, his insistence on extremely high standards, his discontent with actual accomplishments, his worry over inability to get the results that he

himself desired might be a source of irritation and friction and restlessness within the organization.

A contrast to this first case is that of a gang foreman of approximately the same age, who complained of lack of ambition and a tired feeling, and who was uneasy on account of certain numb feelings in his hand. There was nothing in the man's condition to give any real basis for this uneasiness. His physical condition was very satisfactory. In the case of this foreman, in contrast to that of the executive, the factors that seemed to have brought on the symptoms were external situations and circumstances and not repressed factors within his own nature. He had worked for two years without a vacation; he had lost a son the year before; his uneasiness over his own condition was partly determined by the fact that his brother had had a mental breakdown, so that he himself was apt to interpret any symptoms in a very serious way.

While in the previous case the symptoms might be looked upon as symptoms of tension, in this case one is dealing rather with symptoms of deprivation. For normal health and efficiency, there must be a reasonable balance of work and play. Life must be of some interest and must offer opportunities for some satisfaction. Where the work is dreary and in itself uninteresting, there must be some source of satisfaction outside of one's work and there must be some reasonable time for this satisfaction. There must be reasonable recreational opportunities in the community, opportunities for social relaxation, and in some cases individuals may need to be encouraged and even trained to use the opportunities for relaxation that are available. The undue emphasis by the patient on his minor physical symptoms was partly determined by the history of his brother's condition. In such cases much can be done to give the individual simple information with regard to the facts of heredity and to remove unnecessary apprehension. As to his bereavement, the extent to which he and his wife had been overwhelmed by this bereavement was, no doubt, partly determined by the very limitation of their lives, the lack of recreation and adequate social relaxation and external interests. In this case again we have, to a certain extent, an obvious health

problem, with disturbing bodily feelings and an attitude of discouragement, but the health problem is only one element in a total situation, that of a worker whose life is unhealthily narrow and one-sided.

From the industrial standpoint it may be a question how far a foreman in a situation like this is a somewhat vulnerable link in the organization. With natural interests and faculties undeveloped, there may, on the one hand, be a feeling of depression and lack of ambition; on the other hand, there may be a vague and slumbering discontent or an underlying resentment of which the individual himself may not be clearly conscious, but which determines his attitude toward the management and toward his fellow workers.

A narrow and restricted life, with lack of recreational and cultural activities, is not limited to the manual worker. Thus a man engrossed in his financial and professional activities had little stability of mood. His spirits rose and fell with the varying fluctuations of business. "I do not know how to play", he said. "I have given up everything to family and business." He was studied as a medical problem, as he had a vague uneasiness and morbid fear, was always anticipating bad news. The analysis of such an apprehensive attitude takes one deep down into the basal forces of human nature. While these forces had manifested themselves in an uneasiness that happened to be brought to the attention of the physician, one can see that this uneasiness and anticipation of calamity and variability of mood might express themselves in a rather disconcerting way in his attitude toward industrial decisions.

At the other end of the industrial scale is the case of a young girl of eighteen who had suffered from fainting attacks and who had told her fellow workers various fantastic stories. On the surface it might seem that we were dealing here with two quite different problems — on the one hand, fainting attacks due to some bodily ailment, and on the other hand, untruthfulness, a problem rather for the moralist than for the doctor. A review of the whole situation, however, showed that the fainting attacks and the fantastic stories were of the same cloth; they represented the romantic and dramatic enrichment of a life which had been seriously thwarted

through rather sordid family surroundings. In such a case the problem is no simple one, to be solved by a tonic or a sedative, but that of gauging the satisfaction which the real situation offers to a girl of a somewhat romantic and imaginative nature. It is not a problem for the physician alone; it involves a study of the patient's industrial environment, the home environment, and the recreational and cultural opportunities available.

The importance of recognizing the personal or emotional origin of physical symptoms in cases of this type, in order that the correct medical treatment may be instituted, is obvious. Failure to trace the underlying factors and exclusive attention to the superficial symptoms may mean an extremely protracted period of incapacity. This is well illustrated by the case of a young girl of twenty-one who was seen on account of vomiting, loss of appetite, weakness, and abdominal pains. The illness had been of considerable duration and was attributed to a slight head injury received in the course of her occupation. Attention had been concentrated on her physical symptoms. The usual technical medical procedures had been applied. X-ray pictures had been taken, chemical examinations made, special appliances worn; a rather drastic operation had even been suggested as a possibility. During all this period the girl had been treated very generously by her employers, so that she had been a source of considerable expense to her company. When a thorough review was made, not only of the physical condition, but of the personality of the patient, of her experiences in life, of her personal difficulties, the diagnosis was that the symptoms were, at least to a very large extent, based upon emotional conflicts. The degree of her incapacity had been determined much less by actual bodily weakness than by the way in which she had reacted to incidental and somewhat trifling symptoms, on the basis of which she had come to play the rôle of a serious invalid both to herself and to others. The explanation of the underlying mechanisms of her trouble was at first received by the patient with some antagonism and protest, but a frank discussion of the whole situation and of her personal problems proved to be of the greatest benefit to her.

From the medical standpoint, such a patient presents many

fascinating problems with regard to the original constitution of the individual, the molding factors of her life, the special situations that offer most emotional difficulty and are most likely to lead to such a type of invalidism. Why does this patient break down in relation to a situation that others can meet without special difficulty? Why do the physical symptoms take this form rather than that form? Could better training in childhood, the formation of better habits, a more open and intelligent and tonic atmosphere, have prevented the later symptoms? What is the precipitating factor that causes the symptoms to develop just at this time? Why do the symptoms persist for such a long time? Each one of these topics would furnish a subject for a prolonged and intricate discussion of a very technical nature. The broad, outstanding factors, however, are simple.

The case is that of a young woman who, after a trifling accident of little importance, becomes incapacitated for months while her organization treats her in a considerate, even generous way. The duration of the symptoms and their intractability were perhaps in part fostered by this generous and tolerant attitude of the organization. On the basis of her symptoms, she received compensation, was an object of sympathy and concern to friends and family, and, at the same time, found a safety valve for the inner tension connected with instinctive and emotional factors. It must not be assumed that in such a case there is conscious deception or that a patient deliberately tries to deceive others. On the other hand, the duration of the incapacity is to a large extent determined by the gain derived by the patient from the incapacity, a gain that may be partly financial and partly psychological. In this case there had been a minor injury and this was used as a peg upon which the clinical symptoms were hung.

The way in which a worker responds to an injury, the degree and duration of the incapacity, are, to a large extent, dependent upon the personality of the worker and the way in which the situation is handled by the management. In some organizations this is recognized, and the situation is treated with great wisdom, so that there is the minimum opportunity for the worker to develop an unhealthy attitude

toward his injury, to concentrate too much attention upon the incapacity and upon the responsibility of others for compensation, while the maximum attention is paid to encouraging him to look forward to a full resumption of work, and stimulating him to carry on with what capacity he still has. The management thus keeps the worker from being influenced by undue solicitude and by the suggestions of others who overemphasize the disability, and so deals with the problem of compensation that the worker is not preoccupied with the thought that the compensation will be in proportion to his emphasis on his symptoms and to the degree to which he feels incapacitated.

It is in the best interest of the worker himself that the treatment of any injury or sickness should lead to the quickest possible return to health and general efficiency. In the interest of the worker himself many elements that foster a feeling of incapacity, a disinclination to resume work, a tendency towards dependence upon others, should be guarded against. It is well, therefore, to keep in mind—what seems to be quite clear from the study of cases outside of the industrial sphere—that symptoms of the most varied type may be perpetuated by the attitude of those around and by the advantages that accrue to the individual from the existence of symptoms. Those who have been in close contact with the problems of the disabled soldier realize how detrimental to the individual soldier has been the tendency to keep his mind focused on the problem of compensation rather than on that of the resumption of life's activities. The same factors that tend to foster emphasis on the results, real or fancied, of some injury are also at work in connection with the other ailments that assail the industrial worker, and here, too, the degree and duration of the incapacity may be related to personal factors, which must be kept in mind by the medical personnel and by the management.

The extent to which such personal factors interfere with the continuity of the industrial career of the worker is illustrated by the case of a young woman who was working in the same organization as the patient just mentioned. In the present case the symptoms were those of some respiratory distress and a certain general nervousness. Here, too, there

had been a detailed review of the bodily functions, and the patient had received medical care for a considerable period and for many months had been at home, apparently unable to go on with her occupation. Her preoccupation with her symptoms was in great contrast to her actual physical condition, which was quite satisfactory. Her restoration to a healthy attitude toward the resumption of work, with disappearance of the symptoms, was dependent upon her facing honestly various personal difficulties which had been a source of great concern to her, but had never been discussed.

In many cases the incapacity of the worker, whether it take the form of physical symptoms or of some peculiarity of attitude toward those around or toward self, is based upon personal factors closely related to the instinctive life which are seldom discussed except in the frank atmosphere of a medical consultation. The benefit to the worker of a frank discussion of some of the fundamental issues of life may be very striking. The following case illustrates this relationship of work inefficiency, nervous symptoms, and underlying human difficulties.

The patient, a middle-aged man, was suffering from headache, somnolence, and odd head feelings. He had lost his usual ambitious and progressive attitude toward his work. Examination showed no physical disorder except undernutrition. There was a lack of harmony at home, and his wife had rather rigid and puritanical standards. The situation was not unlike that of the first patient whom I referred to in this paper—the executive who tried to find an outlet in a missionary attitude toward his environment. In the present case, a thorough discussion of the fundamental issues that were at the basis of the domestic discord, and the placing in the hands of the wife of a book which gave her much information and a completely new attitude toward the basal factors of human nature, brought about a complete transformation of the domestic situation and the disappearance of the symptoms that had brought the patient to the attention of the physician.

These few cases, presented in a very sketchy way, illustrate the problems that come to the attention of the physician. In dealing with the symptoms of his patients, he sees the im-

portant rôle played by personal factors, the importance of the fundamental instincts of human nature, the influence of the domestic, the social, the industrial situation upon the development and the persistence of symptoms. He sees that the underlying forces uncovered in his study manifest themselves, not only in medical symptoms, but also in reactions in the schoolroom, the store, the factory, and the office. He wishes to make his data available to those who are working in the school and in the factory, so that they will have a still fuller grasp of the personal problems and needs of those with whom they are in contact, not to mention a fuller grasp of the problems that determine their own personalities, their attitudes toward life, their standards of values.

Where underlying difficulties express themselves on the surface through physical symptoms, the individual is liable to come fairly early to the attention of the physician. But where the same type of underlying difficulties express themselves in a somewhat changed attitude toward fellow workers and toward the job itself, the physician may not see the individual at all while the individual is one of the problems of industrial management. The management has to take account of workers who feel rather sore at other workers or groups of workers, who feel that they are discriminated against, who see hostility and injustice in the attitude of others toward them. It is perhaps generally realized that if a foreman is having difficulty with too many of his men, the fault may be in himself. It is not easy, however, to check up on one's self without the aid of some detached observer. The same repression of underlying factors that has led to the friction is apt to lead to a certain blindness when we try to scrutinize our own conduct. An example of the way in which the individual sees in the behavior of others a disturbing attitude toward himself, which has its root really within his own personality, is furnished by the following case.

The worker, a man in the thirties, had been promoted to be a foreman and now felt that his fellow workers did not like him. They did not seem to respect his authority. "I felt that the men were trying to put the skids under me at work." As a matter of fact, the patient felt a great deal of diffidence about his ability to play the rôle of foreman. He

had lost confidence in himself. This loss of confidence, however, seemed to have its origin, not in any real inefficiency, for he was an excellent workman, but in his self-reproach over his domestic life in which he felt that he had been disloyal and criticized himself rather severely. There seemed reason to see this personal discontent with his own private life as the real basis for what, on the surface, was a statement that those who were working with him disliked him and were essentially hostile and critical.

In a similar way the persistence of an old repressed attitude of resentment against parent or teacher may show itself in the industrial environment as a somewhat exaggerated and inappropriate resentment of all authority and discipline.

The practicing physician has his own special occupation of looking after the ailments of those under his care. In addition he has an interest in promoting research into the causes of the troubles that he is studying; he has an interest in the health of the community at large and in the wider problems of social welfare.

Those who work in industry have their specific tasks, but besides their interest in their own technical task, they may have some interest in promoting research into the various factors that influence the welfare of an industrial organization; they may have an interest in the social welfare of the community. Even in doing the special task, it may be of some advantage to them to have a more specific knowledge of the way in which underlying personal factors influence the total behavior of the individual, whether the individual be a worker at a repetitive task, a skilled craftsman at his special job, an office employee dealing with mental operations, a foreman supervising and managing human material, a manager organizing, planning, coördinating, a salesman with his special problems of appeal and influence, a president inspiring, dominating, delegating authority, making decisions, employing strategy.

What can the physician say in general about the individuals who compose the highly organized industrial community? What is the common denominator? The common denominator is the basal endowment of human nature. The underlying

driving forces of human nature are the same, from the worker at the machine to the president in his office. There are variations in the quality and degree of these component forces, but each individual is aiming at some sort of harmonious satisfaction of these component tendencies. The urge to live, the urge to love are common to all; fear in the face of danger and uncertainty, anger in the face of thwarting, are the heritage of each one. Satisfaction from the approval of one's fellows plays some rôle in determining the behavior of each one, and each one has some standard of values, some code, some scheme of life, whatever may be the origin of this scheme and however vaguely formulated it may be.

It is with these common factors that the physician has to deal. In the face of pain, of weakness, of unhappiness, of incapacity, he has to examine the common factors in human nature; he has to put aside all conventional reticence and to deal with life in its bare reality. Where it is a question of life and death, whether of the body or of the mind, reticence and reserve are out of place, and the physician has to study human nature and human situations with a directness and frankness that no other situation makes quite so imperative. In the study of the physical and mental health of his patient, the whole patient has to be explored—his physical organs, his emotions, his instincts, his early home influences, his intimate past experiences, his present life situation. The physician cannot fail to be impressed with the subtle ways in which the deep, underlying forces of human nature express themselves above the surface in symptoms and behavior, the significance of which is so apt to be misunderstood. He feels that the knowledge of human nature thus derived is of sufficient importance for him to take the initiative in bringing it to the attention of the teacher, the religious adviser, the sociologist, and the industrialist, so that there may be greater coöperation in the interest of the common welfare.

THE MENTAL-HYGIENE ASPECT OF THE BOY-SCOUT MOVEMENT *

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MANY attempts have been made to place boys of the adolescent age in groups under adult leadership with the chief purpose of affording guidance in the boy's physical and mental development. In 1910, the Boy Scouts of America were chartered by Congress and since that time have been one of the greatest socializing forces for the adolescent boy. The great bulk of the Boy-Scout organization is composed of units of thirty-two boys, or less, known as the "troop", under the direction and leadership of a volunteer adult "Scoutmaster" and his adult assistants. Where there are sufficient troops in a locality, they are centralized under the direction of a paid "executive" into a "council". Various councils are grouped together under a "regional executive", all of whom are responsible to a "national council", headed by the "chief Scout executive".

The purpose of the Boy-Scout organization, as stated in its constitution, is "to promote, through organization and coöperation with other agencies, the ability of boys to do things for themselves and others, to train them in scoutcraft, and to teach them patriotism, courage, self-reliance, and kindred virtues". The organization recognizes the religious element in the training of the boy, but it is absolutely non-sectarian in its attitude toward that religious training. It definitely avoids all questions of a political character and specifically states that military training and drill shall not be included in the program.

The program of the Boy Scouts of America is carried out through the organization of the troop, which consists of at least one, and not more than four, patrols of eight boys each,

* The author of this article has had seventeen years of experience in the Boy-Scout movement and at the present time is Scoutmaster of a troop that has twenty-four Eagle Scouts, the highest rank in the organization.

each patrol being under the leadership of a boy—the "patrol leader". Only boys who have passed their twelfth birthday are eligible for membership, and the upper age limit is eighteen years. The program is one that recognizes the achievements of boys by the award of degrees and badges which designate them progressively as Tenderfoot, Second-class, and First-class Scouts, and by the award of special-merit badges for proficiency in the subjects of woodcraft, art, crafts, agriculture, science, nature study, physical development, and so forth.

All Scouts must know and subscribe to the Scout oath and law. The oath is as follows: "On my honor I will do my best to do my duty to God and my country and to obey the Scout law; to help other people at all times; to keep myself physically strong, mentally awake, and morally straight." In subscribing to the law, a Scout promises to be trustworthy, loyal, helpful, friendly, courteous, kind, obedient, cheerful, thrifty, brave, clean, reverent.

Upon demonstrating his ability to repeat the Scout oath and law in full and his thorough knowledge of their meaning, and in addition learning certain knots, the history of the American flag, and a few other things, a boy is entitled to wear the Tenderfoot badge. After a month's service as a Tenderfoot, he may qualify as a Second-class Scout by learning some of the simpler forms of first aid, tracking, fire building, and elementary signaling and cooking; starting a bank account; and fulfilling some other simple requirements. After sixty days' service, he may qualify for the rank of First-class Scout by passing certain more difficult tests, including swimming; advanced signaling, first aid, and cooking; map making; hiking; and nature study. He may then advance by demonstrating his knowledge and skill in one or more of some eighty-five fields of endeavor — such as archery, architecture, athletics, camping, bird study, dairying, life-saving, photography, surveying, and so forth.

By acquiring any five merit badges, a Scout may qualify as a Star Scout; ten merit badges make him a Life Scout; twenty-one — eleven of which are specified — give him the highest rank award in Scouting—that of Eagle Scout.

The basis for the success of the program of Scouting from

a psychological point of view lies in its ingenious methods of applying and uniting various psychological factors, all of which are particularly beneficial from the standpoint of mental hygiene.

The first of these psychological factors is the appeal made to the ego and the gratification of ego desires. The program brings a boy to a new awareness of himself. He voluntarily begins to educate himself to qualify as a Boy Scout—a step he may have looked forward to for years. He crosses a threshold of new opportunities that open up visions of much romance and interesting experience. He acquires the privilege of wearing a uniform. He is introduced to ceremony and government. He is given the opportunity to advance in rank and he may decorate himself with his awards to display his accomplishments. He becomes aware of positions of responsibility that are open to him as soon as he qualifies himself for them. He is invited to test himself, and the whole plan of advancement in the Scout program is an individual affair which is rarely, if ever, colored by group competition. Every test is a personal problem, and the Scout competes against nothing but his own impediments of lack of skill or knowledge or ability. Thus, as stated in the report of the Committee on Habits of Conduct as Fostered by Scouting,[1] if the Scout wins in the test, he is a more skillful, useful, serviceable, dependable individual to himself and society. If he loses in the test, he is still a winner because he has made progress in the pursuit of good habits and has attained a certain measure of initiative and self-mastery.

The second psychological factor that works for the success of Scouting is the development of a group consciousness. Much has been written about the natural growth of a boy out of his family bondage into the "gang". The troop becomes the "gang" and supplies the common interests, the mutual objectives, and the opportunity of group association, but it differs from the usual "gang" in its continuity and adult leadership. In the writer's experience, the majority of boys who join the Scout troop are attracted to it primarily because their friends are members. They join to become a

[1] Submitted at the Fourth Biennial Conference of Scout Executives, Hot Springs, Arkansas, September 22, 1926.

member of the gang. The Scout's uniform identifies him as belonging to a great group, and his colored neckerchief, which is a part of that uniform, identifies him with a particular local group, around which more or less group morale, tradition, and distinctiveness always crystallize. The troop usually gets together each week, and this group consciousness is purposely strengthened. There the younger boy is brought into direct contact with older boys and adult leaders. This gives the boy of twelve or thirteen years an unusual opportunity to become intimately acquainted with boys of seventeen and eighteen years, and the younger boy's desire to emulate the older boy is accentuated much more than in the ordinary "gang" because of the plan of Scouting, the exhibition of insignia and badges that show accomplishment. The older boy, on the other hand, is stimulated to further personal development by the responsibility of leadership vested in him.

The third wholesome psychological factor in the Scouting program is the direction of the boy's energy into purposeful lines of activity, into the acquisition of useful facts and practical accomplishments. The boy is introduced to a great variety of new interests, covering every field and presented in such a way as to appeal to boys from the age of twelve even past the upper limit of eighteen years. The tests are literally a man's job cut down to a boy's size, and there is sufficient variety to appeal to the versatility of the average American boy.

The technique of this introduction to knowledge is regarded as unique in our present educational development by certain of our leading educators, who praise the educational value of Scouting in glowing terms. For example, James E. Russell, while Dean of Teachers College, Columbia University, has expressed himself as follows: "The Scout program is essentially moral training for the sake of efficient leadership. It gives definite embodiment to the ideals of the school, and supplements the efforts of the home and church. It works adroitly, by a thousand specific habits, to anchor a boy to modes of right living as securely as if held by chains of steel; but best of all, it exhibits positive genius

in devising situations that test a boy's self-reliance and give full leadership. These two aspects of the Scout program are so evenly balanced and so nicely adjusted as to make them well-nigh pedagogically perfect. The entire organization is a machine capable of working wonders, not only in the moral regeneration of the American boy, but also in fitting him to assume the duties of an American citizen." And Lotus D. Coffman, President of the University of Minnesota, has stated:[1] "Scouting gives no long lectures on vocational guidance, and yet it teaches the meaning, the importance, and the dignity of work; it operates no bank and yet it teaches the meaning of thrift; it maintains no jail and yet it teaches the meaning of self-control; it does no preaching, and yet it teaches devotion to a cause and loyalty to a purpose; it is founded upon no religious creed or sectarian doctrine and yet it emphasizes above all things the importance of religion. It is universal in its appeal, natural in its methods, progressive in its outlines, strengthened and cemented by the bonds of fellowship, and the idealism of the movement. Majestic in its conception, it is nevertheless simple and direct in its appeal. I believe in it so fully that I can truly say that I would rather have been its author than to have been the author of any other thing I can think of in the whole field of social theory and practice of my day and generation."

Dean Henry W. Holmes, of the Graduate School of Education of Harvard, and Professor William H. Kilpatrick of Teachers College, Columbia University, have also made public statements of their opinion as to the unusual educational advantages of Scouting.

The fourth and perhaps the most powerful psychological factor in the application of the Scouting program is the transference developed by the Scout to his Scoutmaster. By transference, the writer refers to the unusual interest, akin to affection, which the Scout develops toward his leader. The Scoutmaster figuratively becomes the idol, the hero, the originator, and the father, and the boy, the idolator,

[1] Quoted from *Scouting in Relation to the Schools*, by Ray C. Wyland. New York: Boy Scouts of America, Department of Education, 1927.

the worshiper, the follower, and the son. He responds to his leader with an unstinting devotion of time and energy to assigned tasks and loyalty to ideas, and follows out the leader's suggestions to the limit. Just in so far as a man can obtain this transference from boys will he be a successful Scoutmaster, regardless of his technical knowledge of the organization and program of Scouting.

Failure on the part of the Scoutmaster to appreciate this point is probably one of the weakest features in the whole organization of Scouting. The Scoutmaster is a volunteer contributor of his time and energy, and far too often he takes his job reluctantly and even unwillingly. For the most part he has had no training in Scouting, and, far more important, he is more or less ignorant of the mental-hygiene aspects of adolescence. Often he accepts his job as his contribution toward the constructive program of his church or his community and entirely lacks any insight into the task he has undertaken or his own equipment for handling it. The intentions of such a Scoutmaster may be commendable, but his troop is not as a general rule successful.

Scoutmasters may fail because they are not aware of the necessity of obtaining this transference, or because they do not know how to obtain it, or because, having once obtained it, they cannot capitalize it. In the first case, they regard their job of Scoutmaster as a task to be got through and fail the Scout movement in proportion to their apathy. In the second case, they fail to lead; they look to their Scouts to educate them, to blaze the trail over which they themselves have never gone or even indicated their intention to follow; they expect their boys to be something different from themselves. In the third case, they may be highly successful as boy leaders, but because of their ignorance of, or apathy toward, the Scout program, their groups are rarely successful as Scout troops.

The effect upon a boy of a successful Scouting experience varies with many factors, but depends primarily on the type of Scoutmaster he has had. Assuming that he has progressed through the various Scout ranks to the highest, that of Eagle (as over 5,000 boys in the United States did

in 1927), he has probably come into contact with many psychological forces that he would have missed entirely outside of Scouting. Aside from the stated purpose of the organization—"to teach patriotism, courage, self-reliance, and kindred virtues"—which is successful in varying degrees, though difficult or impossible to measure, Scouting offers definite opportunities for mental-hygiene work with boys. Among these are the following:

1. *The development of life interests.*—One of the purposes of the merit-badge program is to serve as a guide to the boy in the field of pre-vocational study. Unfortunately or otherwise, this purpose is rarely fulfilled. On the other hand, the whole program lends itself excellently to the development of life interests and hobbies. The emphasis on nature study develops many devotees who carry on their interest in birds or flowers or trees long after they leave Scouting. This is occasionally true also of the Scout's interest in other merit-badge work—art, aviation, crafts of various types, hiking, marksmanship, photography, radio, taxidermy, and so forth.

In all such cases, the value of a creative avocation carried over from the Scouting experience into adult life is of inestimable value. Psychiatric study reveals almost universal introversion in schizophrenia and characteristic introspection in psychoneurotics. In a surprisingly small percentage of such cases has the individual ever developed an avocation. Consequently, if the Scout can develop any kind of lasting avocation from his contact with Scouting, the organization has contributed heavily toward that individual's mental health.

2. *Dexterity in masculine accomplishments.*—The Scout program teaches as a matter of routine many very desirable activities that are distinctly masculine in their natures. Proficiency in feats such as fire building, the use of knife and hatchet, knot tying, swimming, and the like, is desirable for every boy—and for every man—and Scouting admirably includes them and many similar activities in its program. The psychological result is apparent. Every Scout is more or less aware of this advantage and develops a sense of con-

scious pride in his accomplishment. Particularly is this point of value in the case of the effeminate type of boy; his Scout accomplishments tend to counterbalance his feminine attributes and focus his attention on further masculine efforts.

3. *Socialization.*—As stated above, the development of group interest and consciousness is a psychological factor that contributes heavily to the success of the organization. It has, moreover, a good result in the way of educating and influencing the schizoid personality toward a more healthy social extroversion. Undoubtedly many seclusive and asocial boys are tremendously helped by being required to participate in patrol and troop undertakings, and an even larger class of boys are benefited by their introduction into and their development of a group consciousness. They are impressed with the idea of "making good" for the sake of the whole patrol or troop and with their responsibility as individuals to contribute to group success. Joining a Scout troup is often the first occasion on which a boy is obliged to adjust himself to working harmoniously with other boys, and Scouting offers an excellent opportunity for him to develop this ability. If ideally conducted, the program gives the older boys the responsibility of helping the younger boys, so that a Scout's rôle gradually changes from that of a student to that of a teacher and from that a follower to that of a leader.

4. *Group enforcement of standards.*—The Scouting program admirably outlines an ethical code of high standards. Whether these standards are carried out in the small group depends largely on the Scoutmaster. The enforcement, however, if successful, is almost entirely in the hands of the group. When successful, the mental-hygiene effect on the individual is of tremendous advantage. The group forces him to be neat, to be snappy, to be interested. It compels him to conduct himself within approved limits. It establishes a moral tone and enforces it upon its members much more effectively than any one single opinion could. This self-enforcement of an admirable code during the formative years of adolescence is of exceptional value to the subsequent mental health of the individual.

5. *Emulation of the leader.*—Probably the most fruitful opportunity for mental-hygiene work in Scouting lies in the guidance given by the Scoutmaster to his Scouts. In the ideal troop, the Scoutmaster holds a place in the Scout's admiration and affection second to no one except perhaps the boy's own father. As a result, the Scout seeks and accepts the advice of his Scoutmaster during a period of development when, were it not for this contact, he would probably be without confidential adult counsel and advice. At an age when the family's influence on the boy is beginning to wane, his admiration for his Scoutmaster will lead him to emulate this leader in many ways. Depending, of course, on the amount of transference established toward the Scoutmaster, the Scout will accept his leader's ideals and standards and opinions. He will form his likes and dislikes after the model of his leader and formulate his approval and disapproval as his leader suggests. The opportunity for the Scoutmaster to play the rôle of mental-hygiene counselor is unexcelled, and in fact he often does so, for better or worse as his equipment and training permit. By obligating its leaders to subscribe to the Scout oath and laws, the Scout program protects itself, and unquestionably the general result is decidedly beneficial.

SUMMARY

The Boy-Scout movement is one of the most powerful and probably one of the most effective programs of mental hygiene for the adolescent boy. The psychological methods that contribute largely to its success include conspicuously the gratification of the ego desires, the development of a group consciousness, the direction of the boy's egoistic libido into purposeful, creative paths, and the transference established with the Scoutmaster. The more important beneficial mental-hygiene results accomplished are the introduction of life interests, the acquisition of proficiency in strictly masculine accomplishments, the development of group sociability and coöperation, the group enforcement of moralistic standards, and the emulation by the Scout of his leader.

PSYCHIATRIC SOCIAL WORK, ITS NURTURE AND NATURE*

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"PSYCHIATRIC social work"—those three words have such different connotations for different people. At one time not long ago, in a discussion of the problem of persuading a municipal body to employ social workers, it was suggested that the difficulty might be solved by recommending psychiatric social workers. The chairman of the committee, a leading educator in the social-work field, immediately vetoed the suggestion, explaining that the type of individual to be dealt with was not the feebleminded, but "ordinary normal people". This attitude and that of the present-day social and health agencies which are employing psychiatric social workers in an advisory, educational capacity represent the two extremes of opinion with regard to this comparatively new development.

These points of view reflect the trend of the times not only in psychiatric social work, but in the field of mental hygiene also. The progress of the mental-hygiene movement resembles that of the public-health movement. First came study of and improvement in the care of the mentally diseased and defective and popular education in regard to the significance of these conditions. During this period after-care work with paroled patients from state hospitals and increasing realization of the significance of social behavior in determining diagnosis, prognosis, and treatment led to the establishment of psychopathic hospitals for the preliminary study of patients before they were either committed to state hospitals or allowed to return to their homes. At this period the psychiatric social worker as such came into being through the foresight and efforts of Dr. Ernest E. Southard and Mary C. Jarrett at

* Presidential address before the Annual Meeting of the American Association of Psychiatric Social Workers, Memphis, May, 1928.

the Boston Psychopathic Hospital. This led to the establishment of the first course in psychiatric social work at the Smith College School for Social Work.

Psychiatric social work has been an integral part of the mental-hygiene movement since its inception. With increased attention to social behavior, it became apparent that it was necessary not only to treat and care for the mentally ill and defective, but also to carry on preventive work with children. Clinics were, therefore, established to study behavior problems in juvenile-court cases. Child-guidance clinics for the service of communities, habit-training clinics for young children, and mental-hygiene units in schools, colleges, and industries are among the more recent developments.

Not only in the clinical aspects of mental hygiene has psychiatric social work played an important part, but in the educational aspects also. Of course case-work implies the education of members of the family, advice to other social workers in regard to their cases in a clinic, social interpretation of the medical findings, advice as to the personality data required for examination, and so forth. A few selected clinics also carry on field training of students in psychiatric social work at professional schools and offer undergraduate students and others opportunities for vocational observation and for the collection of data for theses. Talks to mothers and other groups are given by clinic workers on the social aspects of case-work.

Community organization, propaganda, and the technical training of general case-workers and public-health nurses in the various aspects and applications of mental hygiene as a preventive measure for *all individuals* are other activities that have been carried on by psychiatric social workers during recent years. These things have been done not as part of clinical work, but in connection with state societies for mental hygiene and family-social-work and public-health-nursing agencies. The question arises whether this type of work is primarily psychiatric social work. It is apparent that the training of the psychiatric social worker in the technical application of the principles of mental hygiene and her education in sociology give her an equipment peculiarly suited to the work of organizing the social forces in a community for fur-

thering mental hygiene and of applying mental-hygiene principles to various forms of group thought—nurses, educators, parents, and others. Does she, however, need the special equipment she has in social case-work? Again to make comparison with the physical-hygiene movement, we find that in the early days propaganda, exhibits, and other forms of popular education were conducted entirely by physicians and nurses. Now, however, practically all of this type of work is being carried on by laymen. Possibly in the future a mental-health worker will be developed who has not the specialized training of the psychiatric social worker, the psychiatrist, or the psychologist. But such a worker in the general educational field of mental hygiene would not be equipped to train the family case-worker who is on the job in the mental-hygiene aspects of social case-work. This work at the present time requires rather a special educational technique which has been developed by psychiatric social workers employed for the purpose by family-welfare agencies.[1] This form of teaching is desirable and necessary at the present time when there are many social case-workers in other forms of case-work who were trained before the theory and technique of mental hygiene and psychiatric social work were included as a minimum requirement in professional courses. Even now this requirement is made only in one or two of the more progressive schools. Eventually, when all social workers have had this specialized training, the present practical method will no longer be necessary.

II

In spite of the increasing use of psychiatric social workers by social-case-work agencies for the education and advice of their workers, leaders in the family-case-work field are asking in what way does psychiatric social work differ from other forms of case-work. Is it not merely an administrative differentiation rather than an intrinsic, technical one? they ask, as well they may. Here is a new development growing, not out of the social-work field, but out of the mental-hygiene field,

[1] See the 1923 Annual Report of the Illinois Society for Mental Hygiene for an account of an experiment carried on in coöperation with the Chicago United Charities.

using case-work technique, but claiming that it is different. To add to the confusion in this curious new growth, there appear to be various concepts and techniques which are not identical within the group of psychiatric social workers themselves.

Where do we actually stand on these questions? It is an accepted fact, I think, that the practice and definition of psychiatric social work varies according to the school of psychiatry in which the psychiatric social worker has been fostered and is working. Those who are associated with psychiatrists of the psychoanalytic school, for example, as a rule seem to consider their social work merely an extension of the psychoanalytic technique to the patient at home instead of at the clinic. They do not distinguish between social-case-work technique and the psychiatrist's technique. On the other hand, psychiatric social workers trained in more eclectic schools of psychiatry, while they may use the same type of psychological approach as the psychiatrist, use it for the purpose of helping in the individual's outside social adjustments, leaving the inner adjustment of personality to the psychiatrist. This type of worker sees the technique of social case-work as distinctly different from that of the psychiatrist. She feels that it is her business not only to obtain data on the social behavior of individuals for the psychiatrist's use and to assist the patient in his social adjustment, but also to discover and cope with all the social problems in the family of the patient.

In spite of these marked differences in approach, which I have roughly indicated, there are essential basic similarities, and it is these that intrinsically differentiate this form of social case-work from other forms. There are, of course, also elements which show that it is a form of social case-work. In the first place, in psychiatric social work the approach to the individual is that of mental hygiene. The worker considers and deals with social adjustments, whether of the mentally ill person or the well person who is having unusual emotional difficulties, always in the light of his behavior and his apparent potentialities for mental health. Her special technique consists of her form of study of social behavior and her methods of dealing with personality, environmental factors, and persons in the individual's milieu in such a way as to

create understanding of causes and motives of behavior, to arouse incentives, and in every possible way to assist in her client's *psychological adjustment within his social life.*

Another important factor in this field which all psychiatric social workers seem to agree upon fundamentally is the point of view or philosophy of mental hygiene which, stated briefly, is the non-condemning, objective approach to all behavior, attitudes, and human relationships. On the administrative side, the approach is always through or in close coöperation with a mental-health unit or agency, and case-work and educational work are conducted as an integral part of a general program of mental health.

It is difficult to define clearly the intangible qualities of an art, especially one so evanescent as psychiatric social work. After reading these statements of differentiating elements, the family case-worker and others might justifiably say that they consider all these in their work. Fortunately, up-to-date social workers are discussing their ideals and standards from the angle of development of personality. Also, many of them are now equipped actually to practice case-work from that angle. The fact remains, however, that the vast majority are not as yet so equipped, even though they may have enough theory to discuss their work from this angle. It is this discrepancy between abstract knowledge and ability to apply it which at present largely prevents these workers from doing work similar to that of the psychiatric social worker. It will take a long time for the approach, the objectives, and the philosophy of mental hygiene as indicated above to permeate and displace the present primarily economic, legal, or health approach of the average non-psychiatric social case-worker.

Little has been said here of the methods of social case-work that have been taken over by the psychiatric social worker from the family-case-work field. The general methods of social investigation, social diagnosis, use of social resources, and case recording, and the application of sociological principles, economics, physical-health standards, and socio-legal facts have all been accepted and adapted by the psychiatric social worker in varying degrees. It is because of this that the fundamental differences are difficult to define. It is needless to point out the obvious fact that if social case-work had

not been developed so fully as it had been in its oldest form, family social work, psychiatric social work would have been infinitely slower in its inception. Because of the youth of this new adaptation and the emphasis on its mental-hygiene aspects, the use of the older tools of social resources and financial and legal aid are frequently neglected or not used to the best advantage. Psychiatric social workers are becoming aware of this and are now attempting to get this equipment.

III.

What, then, are the techniques used by the psychiatric social worker in "her form of study of social behavior and in her methods of dealing with personality . . . and helping with a person's psychological adjustment within his social life"? This is the crux of the question. As yet, in this specialized art of social case-work, there are not enough uniformly prepared data from which to draw conclusions. In the form of study of social behavior, the techniques are not especially new although the emphasis is different. In the matter of social treatment, however, the techniques of the psychiatric social worker are far more conscious and specialized than in other forms of case-work. Various case studies, such as *Three Problem Children* and *The Problem Child in School,* give examples of techniques, but much is left to the imagination even in these excellent reports. Most studies in this field deal with social aspects of behavior, the effect of the environment on later adjustments, rather than with the art of the psychiatric social worker.

The American Association of Psychiatric Social Workers, which now has a membership of about 205, has been studying this question during the past two years. Eventually their findings will appear. Other topics, such as education for this field, relation to other institutions and agencies, and standards of work, are all receiving the active attention of the association. As a suggestion for study topics, the president this year analyzed the various aspects of psychiatric social work and sent out the following suggestions to the local groups of the association. In order to make the program complete, she included the aspects already being actively studied as well as those not yet approached.

Suggested Program for Study

Psychiatric-social-work processes.—At present the association has a *committee on treatment* which ideally would cover such subjects as technique in interviewing; the application of mental hygiene and social treatment; the correlation of the psychiatrist's findings with the psychiatric social worker's methods; the study and treatment of the patients' social interests, such as recreation, education, economic interests, and the like. Besides treatment, the *social history* and *methods of social analysis and diagnosis* might well be studied as separate subjects.

Relations to other sciences.—In psychiatric social work the question constantly arises as to our relationship to psychiatry, sociology, psychology, industrial economics, anthropology, biology, and other sciences which we correlate in our work. The two most closely related at the present time are psychiatry and sociology. In psychiatry, the psychiatric social worker functions somewhat differently with each school of psychiatric thought represented in the various clinics. It might be profitable to study these differences in approach and technique, and also to study the general professional relationship between the psychiatrist and the psychiatric social worker in clinical work. Sociology and our relation to it is becoming more and more an acute problem, particularly psychological sociology, in vogue in some universities and practiced in the community by graduate students. Cultural backgrounds, community organization, and other aspects of sociology are necessary to our work. It would be of interest to see just how consciously we are applying our knowledge to our case-work and how much we are contributing to sociology. The same kinds of problem occur in relation to other sciences and offer limitless possibilities for fruitful study in the future.

Relation to other fields of social work.—The similarities and differences, points of contact, and methods of coöperation with other fields of social work—medical, family, group, child-placement, probation, and visiting-teacher—are being constantly considered by psychiatric social workers in their daily work. Systematic study might help us to formulate our ideas and to profit by a closer correlation between these fields.

Community relations.—Each year sees mental hygiene organized in more states through the formation of societies for mental hygiene and in connection with health and social agencies, schools, colleges, churches, court, child study, and social groups. Psychiatric social workers are being used to carry on this broader community education because of their sociological training, as well as their technical knowledge. With this broadening of their function arise many questions in regard to method of work, professional standing, and the maintenance of technical skill in case-work.

Education and placement.—The association since its beginning has had an active committee on various phases of these subjects, such as academic courses for psychiatric social work in professional schools, supervision of field-work training, advanced education of psychiatric social workers, supervision of staff workers, education of social workers in other fields, placement, and pre-vocational guidance in psychiatric social work. This year emphasis is being placed on the last four phases.

Professional standards.—A committee on this subject was appointed in June, 1927, to carry on work already started on psychiatric social work in relation to general hospitals, state hospitals, and the United States Government Veterans' Hospital and Federal Reclassification Board; also to consider other subjects such as fees for psychiatric social work, prerequisites for practice in our field, salaries,

and working conditions. This committee will coöperate on questions relating to standards with the membership committee and the committee on education and placement.

Very active work has been carried on by the various subcommittees of the standards committee, the newest development being the study of private psychiatric social work. Published reports of the need for psychiatric social work in state hospitals are to appear soon. Under the heading "Community Relations", an energetic committee on psychiatric social work in educational institutions has gathered interesting data on aspects of this new use of the psychiatric social worker. Some of this material will be presented at the open meeting of the association at this annual meeting—1928. The membership committee is studying the intricate question of membership requirements. This has involved careful consideration of the term psychiatric social work, courses in psychiatric social work, and standards of performance.

The committee on methods of psychiatric social treatment is conducting a round-table discussion on the subject at this meeting. Another round-table discussion is being held on psychiatric social work in relation to the work of social agencies. One local group has taken for its year's work the question of the social attitude of the family to various aspects of behavior, such as at school, habits, recreation. In this way the suggested program for study has been followed in part.

In the association are to be found psychiatric social workers in all fields of mental hygiene. They are in schools, social and health agencies, community clinics, traveling clinics, state hospitals, general medical dispensaries and hospitals, mental-hygiene societies. The members also vary in their approach to their work, some having studied in the psychoanalytic school of psychiatry. It is of extreme importance, therefore, that they meet for study of their mutual interests. The possibilities for research and for the development of effective techniques, the conscious use of theory, the development of educational methods are limitless.

The future development of this form of work rests with the association. It will of course always be influenced by developments in psychiatry and mental hygiene and also by sociology and social case-work. Upon the professional social-work

schools will depend the quality and equipment of psychiatric social workers. What the future actually will bring can only be predicted. It is possible that the techniques and approaches of psychiatric social work will be practiced in the entire social-case-work field. Psychiatric social workers as such would then limit their work entirely to research in technique for the use of practicing case-workers. In whatever way we go, it is important that we always bear in mind all of the intrinsic qualities of psychiatric social work.

SUMMARY

To sum up, we see that psychiatric social work was developed as an entity in the field of mental hygiene, having the mental-hygiene approach and point of view. It has adapted the principles and methods of social case-work to meet the socio-psychological needs of individuals. Its techniques are now beginning to be consciously studied and formulated. Its general methods of social investigation, social diagnosis, and application of case-work principles are similar to the methods used in all case-work. However, the *way* in which it makes these applications and conducts social treatment differs essentially from other types of social work. For this reason family-case-work agencies are beginning to employ psychiatric social workers as advisers on their staffs as a means of helping them to make practical applications of mental-hygiene principles in all their work.

There are marked differences in the conception of the functions of a psychiatric social worker among our own group, due apparently to the influence of the various schools of psychiatry with which the workers are associated. However, the essential distinguishing qualities of point of view, approach, and philosophy are agreed upon. The Association of Psychiatric Social Workers serves as a meeting ground for the study of the various factors in this specialized art. Different points of view are represented in the membership of the association and the future development of this field of work depends upon the amalgamation of ideas and the concerted effort of the members. Future developments in mental hygiene and social case-work and the type, theory, and training given by the professional schools are also determining factors in its future.

THE BERKELEY COÖRDINATING COUNCIL

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THERE are several agencies in every community that deal with the guidance and control of youth. Often two or more of these agencies work on the same case, each ignorant of what the others are doing or have done. This is not only wasteful of the time and energy of the agencies concerned, but often is actually harmful in its results on the individual under treatment. If any community is to concentrate effectively its efforts for the treatment of problem children, it must have the unselfish coöperation of all the agencies that have to do with child life. When a problem arises, there should be centralization of information and effort. Each agency must be willing to surrender prerogatives or to accept additional responsibility if the case seems to demand it. All must unite in their willingness to serve in the way that seems best for the guidance of youth and the betterment of the community.

It was to foster this spirit of coöperation in Berkeley that the executives of the police department, the health department, and the Bureau of Research and Guidance in the schools met in the year 1924 to discuss ways and means for a better coördination of our work, especially with reference to salvaging maladjusted children. The group met informally several times; then effected an organization, elected a chairman and secretary, and planned regular weekly meetings. The organization chose for its name "The Berkeley Coördinating Council for Child Welfare". The aims and purposes were stated as follows:

1. To promote the physical, moral, and mental welfare of the children in the community.

2. To coördinate the activities of existing agencies, preventing duplication.

3. To promote personal acquaintance and *esprit de corps* among executives of the various agencies.

The membership of the council has been extended until it now includes the following workers: the city health officer, the superintendent of social service of the health center, the executive secretary of the Welfare Society, the agent of the Charity Commission, the visiting teacher, the director of elementary education, the chief executive of the Boy Scouts, the policewoman, the chief of police, and the director of the Bureau of Research and Guidance of the city schools.

Studies are constantly under way to reveal those conditions in the city which are responsible for maladjustments in children. Also, we seek to know and to encourage activities that contribute to the shaping of a desirable character and personality. We realize that in encouraging the factors that make for good in childhood we serve the same cause as we do when we reduce the power of the agencies that stimulate the bad.

I will mention just a few of these studies in order to illustrate the nature of our work.

A master list has been made showing the names of all youths who have been brought to the attention of each of the coöperating agencies. This list is so arranged that it is possible to tell at a glance which of the agencies have dealt with each child and the cause for which he was reported to each. In many instances two and sometimes four or five different organizations had been dealing with the same problem each in its own way—blindly so far as the rest were concerned. Now a glance at the chart, when a child is brought in, reveals what other organizations may have valuable information with regard to his development, and a telephone call will bring the history of the case and prevent unnecessary duplication. Often the cumulative record for years gives a scientific basis for guidance that would have been impossible on the basis of the brief data associated with the immediate cause for attention.

Spot maps have been made showing the location of the homes of all cases of truancy and delinquency. These some-

times show a focus of infection or contagion that, when followed up, reveals the influence of one individual or a gang on several others who are easily led.

Other lists show the names and addresses of children of very low mentality—those who need supervision or institutional care. Such individuals are always actual or potential problems for the community.

We have listed also the names of all children in elementary and junior high school who are two years or more retarded in school progress. It is well known that retardation is a symptom of trouble. A cumulative case history is being complied for each of these children. In many instances the history brings to light causes of trouble that can be removed. In other cases we find factors that, had they been known and properly adjusted two or three years ago, would have saved much trouble, but that now exert an influence apparently impossible to curb.

How does our Coördinating Council function?

Typical problem cases are discussed in our weekly meetings, and each is assigned to the agency that is in the best position to serve the case. When this agency has finished its work, if more needs to be done, the case is passed on, with all the pertinent data, to the next who can serve, thus avoiding all duplication of effort.

Soon we discover what routing of such cases is best and thereafter that procedure is followed without delay. Always we are seeking the coöperation that will be most effective and most economical of time and effort. Now when a problem case confronts any member of our working force, he knows immediately to whom he should appeal for first contact and support.

Each year we ask the teachers in all the public schools to report to us significant data and the history of every child (1) who is a serious problem in school, or (2) who has some special ability, interest, or aptitude. We define a problem child as one whose behavior varies from the average to such a degree that he cannot adjust himself readily to education in the normal groups in school. The following types of behavior are listed, suggesting the fields in which difficulties

are commonly found: retardation, truancy, sex difficulty, stealing, fighting, lying, nervous instability, cruelty, reticence, or any behavior that deviates from the normal.

The teacher is asked to check whether the problem is present in (1) minor, (2) exaggerated, or (3) abnormal form in any one or more of the ten fields mentioned above. She is also asked to give other significant data on each case.

For the reporting of children who show special aptitudes or abilities, the following suggestions are printed on the blanks: A special ability may (1) be general; (2) involve leadership; (3) embrace a special gift or talent. It may reveal itself in such lines as social activity, literature, science, mechanics, acting, art, music, athletics, and so forth. The teacher is requested to write fully describing the nature of the special ability.

These reports from the entire city are made the basis of a follow-up study by the Coördinating Council through a traveling clinic. This clinic, composed of a psychiatrist, a physician, a psychologist, and a trained social worker, visits each school and works with the principal, the teacher, the parents, and the child. When the school and the home are coöperative, there is the greatest possible chance of reaching problem children at a time when the difficulty is in its incipient stages and when preventive work is most effective. Service rendered at the school is acceptable to parents who would rebel at sending a child to the health-center clinic. Free service furnished at the school seems to produce a very different reaction from free service given at a charity center.

With systematic records kept from year to year of all children who present special problems or abilities, we are building a basis for scientific conclusions that should make the research of our Coördinating Council most significant and far reaching within the next decade.

The question has often been asked, Will this coördinating plan work in other cities, large or small? I can see no reason why it could not be adapted to any city. Berkeley is now organized as one unit. A large city like San Francisco could be organized into as many units as desired, each unit serving its own district. It is purely a matter of coöpera-

tion and organization. Let me emphasize that the essential feature of the plan is the unselfish coöperation of all agencies concerned for the one object—the betterment of the life of the youth in the community.

The outline that follows is presented to show briefly some of the duties and activities of each of the organizations as they relate to child welfare. The outline for each department is very much abbreviated and is presented here merely as suggestive of the work done.

Health Education in the Schools

School nurses:
- Assistance in communicable-disease control.
- Detection and correction of physical defects.
- Health education of parents, teachers, children.

Dental hygienists:
- Examination and recommendation for all school children.

Director's office:
- Reports of health findings and recommendations to Bureau of Research and Guidance, police department, physical-education department, and all coöperating agencies.

Berkeley Health Center

Therapeutic services to those unable to employ a physician.
Preventive services through lectures, conferences, and immunization.
Child-guidance clinic.

City Health Department

Collection of vital statistics.
Communicable- and preventable-disease control.
Water, milk, food, and sanitation (same throughout city).
Coöperation with school, police, welfare department:
- By acting as field health agents
- By obtaining parental support for family plan when required
- By bringing to bear upon problem children the rehabilitation forces of educational, police, welfare, and character-building agencies
- By reciprocal notification of findings and recommendations to all coöperating agencies.

Berkeley Welfare Society

State aid for needy children:
- Orphans
- Abandoned children
- Illegitimate children
- Children of fathers who are incapacitated
- Juvenile-court children committed for dependency.

Group and individual conferences to work out plans with other social and health agencies for rehabilitation of families.

Bureau of Research and Guidance

Investigations and recommendations on all problem cases referred to central office by principal or outside of school agencies.

Surveys of problem children and children with special abilities and aptitudes.

Administration of tests to check on ability and progress of school pupils.

Classification of pupils or assignment to special classes on basis of needs.

Educational, social, and vocational guidance of all school children.

The Police Department

Investigation of complaints received by the police concerning:
- Juvenile delinquency
- Defective home conditions
- Defective neighborhood conditions.

Supervision of public places of amusement and other places where juveniles may congregate.

Supervision of delinquents and potential delinquents.

Promotion of development of:
- Community centers
- Character-building organizations
- Civic-betterment organizations.

Coöperation with health, school, and welfare departments.

Conduct of educational campaign dealing with causes and prevention of delinquency.

TO A GRADUATING CLASS OF GENIUSES

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TO talk to you for even fifteen minutes is a task. If I were not a psychiatrist, I should not attempt it.

Each of you must have a gift, or you would not have been allowed to enter this college. Here for four years you have studied the ways of developing that gift and, of course, those of you who have been most successful have become most insecurely balanced. Your diploma waiting for you on this platform certifies that you are expert, proficient, and lop-sided; it assures the world that you are predisposed to greatness and to trouble. Your gift gives you a problem in balance that ordinary people do not have. The converse of this statement appears in a novel I am reading: "Una was the least clever and the best-balanced one in the family."

And then you, both by birth and training, are made different from most people. You need no argument to convince you of that.

On these two points the psychiatrist is able to speak. His patients are unbalanced and different from most people. Why mental patients are easily upset, and why certain barriers isolate them, ought to be of very practical importance to you.

One matter ought to be settled at once. Wouldn't it be better for you, immediately upon graduation, to go to a sanitarium and stay there? There you would find even conditions of life, tempered winds, helping hands to keep you steady. You would not realize your difference from the crowd, because you would not see it and would not have to do the things that it does. Bases for invidious comparisons would be absent. For a certain price you would find unending tolerance and sympathy. The world of common sense would be kept out, with the butcher and baker and candlestick maker who insist upon treating you as they do any one else. "The world well

lost." If you wanted to spend twenty years in writing a book, as a friend of mine did, with no expectation that any one would ever read it, you would have that privilege. You will recall that in the Middle Ages the artists sought the protection of the monasteries, with satisfaction all around.

But it is not until they reach the age of fifty that most artists see the advantages of sanitarium treatment. You probably choose life; your arms are cordially wide open to it, although you know that it has proved too much for most geniuses. Life has proved too much for most mental patients, too, and I want you to consider them for a while.

It is just this unescapable (except by sanitaria) business of living that mental patients have to teach. In their failures and successes, they always have been great teachers, but no one has been willing to stoop to learn from them. But how can we learn as much from people hopelessly right side up as we can from those who see the world from many different positions? Real teachers have a queer streak in them. Think of what Alice found "Through a Looking-Glass"—how much she learned "In Wonderland" as she ate the mushroom and changed sizes in a twinkling. That Lincoln in young manhood was abnormally depressed was a thing that let him enter into phases of human experience that were closed to his more steady contemporaries. Consider Mr. Hamilton's lines on the innocence of Father Chesterton:

> "Standing, in dangerous balance, on his head,
> He sees mad, lovely marvels round him spread,
> And wins, with wild feet menacing the sky,
> The artist's awful innocence of eye."

The things that mental patients have to teach gain value from the psychiatrist's universal observation that the more closely the normal and abnormal activities of human beings are studied, the more they tend to coalesce. Explain one and you explain the other. Mr. Gamalial Bradford, on one page of his *Life and I*, gives four quotations which make it appear that psychiatrists have found only special instances of general rules. He quotes Emerson: "There is one mind common to all individual men. Every man is an inlet to the same, and to all of the same." And Mark Twain: "I become more convinced that I and other men are alike, and that what virtues I have

are the virtues of others, while the vices of others are all to be found in me." And Voltaire: "With a little imagination and one's own heart, one may understand everything in humanity." And Sainte-Beuve: "One can get to the depths of human life without ever going out of one's self." To Mr. Bradford's collection we can add Heine: "I am tragedy, I am comedy—a beast, a devil, a god." And especially is there a wide "inlet" into the hearts of geniuses and common men through their neurotic and psychotic brothers.

Please do not think that a psychiatrist sees so much abnormality that he thinks every one is queer. Rather he sees the normal where others do not—sees normality not as a chalk line drawn for us, not as a strait and narrow gate through which to make other people walk, but as a very wide road, its hazy margins disappearing in the distance. Normality should have room for the American banker and the Mahommedan beggar. To be normal does not even imply being average. Let me give some illustrations of normal explanations and abnormal behavior.

A young woman on a central-Pennsylvania farm became so seclusive and so indifferent to her family and its interests that her father brought her to a psychiatric clinic. Here it was established that her "abnormal" behavior was a normal defense against a family in whom religious fanaticism had destroyed all sense of proportion. Withdrawal in this girl was a preliminary to contacts with normal people, whom she found first in a mental hospital.

Many boys in colleges have had to act "queerly" and unsociably to escape from being absorbed into frenzied athletic activities. They are sometimes so well balanced that they are isolated.

Dr. Fernald could see, as the less wise could not, that many "truants" were good boys running away from a bad school.

Which brings us back to the value that the study of mental patients has for everyday life. Mental patients are fighting your own battles for you, with some important changes in conditions. Your knight in the tournament wears an identifying color; he is all Sorrowful, or all a Daydreamer, or all Activity; there is no doubt about him, no halfway measures. In everyday struggles there is no such plain marking; a knight fights

under a dozen different colors and tries to deceive you and himself about what caused his success or defeat; a cloud of dust envelops the field, and you wonder what the fight was about. But the mental patient wears his heart on his sleeve; he stays under the same color, come what may; he carries his one quality to its logical conclusion. His unwillingness to compromise may lead him to disaster, but it allows the bystanders to know what happens when unalleviated unselfishness and unmitigated reasoning are carried to the extreme. In the confusion of modern life there still remain some allegories to guide us.

Of all the banners under which mental patients fight, perhaps the delusion is the most characteristic. Suppose we define it, with the hope that no one will look too closely at the definition, as a false belief due to disease. We know certain things about it; it is not a haphazard thing to the patient, but the outgrowth of some of the patient's needs; it is attached to and dependent upon an emotion, and we see that it disappears as the emotion recedes; it is carefully and desperately protected against information. It is a sign of a closed road. Its ultimate origin may be in ignorance and accident, but it rises superior to all the enlightened and valid arguments that can be brought against it. These important facts can plainly be seen in mental disease, but they can be applied elsewhere.

For one patient ruled by delusion there are hundreds of well people ruled by prejudice, and it can be seen that every word applied to delusion except the word "disease" may be applied also to your pet false beliefs. The sign, "Road closed", is plain enough. Mr. Crothers put a definition of prejudices into a definition of tact "as the ability to find out before it is too late just what our friends do not want to learn from us". Our friends fly to the defense of a prejudice with a passion ridiculously too great for the trifling issue.

Some prejudices are harmless, some are interesting and colorful, but others are always pressing us to injustice to our present-day neighbors. There is something repugnant to those who love freedom in not being able to decide freely a present issue, and in being forced to bring to it a decision founded upon some past event which has no bearing on the case. A man I know is trying to treat his companions justly,

but he cannot because he has always to take the part of the under dog; his attitude now is determined by his father's unfairness long ago.

Geniuses tend to have prejudices against the common herd, and the common herd tends to have prejudices against them. It is not hard to trace the origin of your false belief that the herd, the well-ordered life, and conventions are all inventions of the devil. Your parents, teachers, and playmates did not recognize your unusual gifts and tried to force you along standard paths at a pace set by almost the slowest of your contemporaries. If some authority is linked in your minds with a just anger at its foolishness, then all authority brings out that anger. Freedom cannot exist with a prejudice against authority; unless you are free to accept as well as to reject rules, you are a slave to something. The world has had enough spectacles of artists battering their heads against some law because, when they were children, some one spanked them for the infringement of a petty rule. Such spectacles are understandable, but none the less infantile and unedifying.

But while you geniuses have much to endure from common people, they in turn have much to endure from you. In some way or other they have to forgive your superiority. They have to watch you trampling over rules that they know are good for themselves. If genius is a "divine release from inhibitions", it must be very hard on the neighbors. They allow you certain privileges which you share only with mental patients or with children—to be peculiar in dress, to be open in speech, to be less ashamed of having emotions, to be impractical. And after all, the little excellencies of the many, the common habits of common people, form a basis and a demand for the sky-reaching towers you build. How far would a musician go in a country that had no musical instruments? What a satisfaction to Cèsar Franck, at sixty-nine, to think that some people were beginning to appreciate his music!

And as you prepare to leave these sheltered halls, it will pay you to examine the experiences that mental patients have had with emotions. What has been their training in emotional control? How does it differ from yours?

Every college graduate has received two contrasting edu-

cations—one for his special work and one for his life. You, for instance, began as children a reasonably consistent and well-planned schooling for your work. Simple exercises led to harder ones. From kindergarten to college there were graded lessons—not so well graded for you exceptional souls, but still showing order of a sort. And as infants you began another education, a training for loving and living with other people. As you look back, where is the order here? Where the grading? Where the curriculum? Mental patients help us to look back; they tell us that baby problems were brought to them in adolescence; that grown-up lessons came to them when they were babies; that there was no system in it.

In that intellectual schooling, which in comparison shows a remarkable consistence and progression, you found that the multiplication table, once learned, could be relied upon later; no one tried to pull it out from under you. In geometry no one tried to replace an early theorem by such a one as was proposed by an interesting boy: "Things equal to the same thing are equal to anything else." But in our emotional training attacks upon and substitutions for early theorems are being attempted constantly. The first lesson in the book says, "Mother love is everything good." Further along we find, "Mother love is the origin of all evil." An emotional attitude fixed in us by some bitter experience ought to be unlearned because it turns out to be mistaken. When John was a helpless baby, a woman let his feet freeze; John naturally wanted nothing more to do with women; he is now trying to unlearn his lesson.

The intellectual training of the artist, his technique, can be graded and passed. The diploma ready for you on this platform guarantees your success—in an Arcadia; it is seldom that intellectual ability and skill ever fail any one, once they have been present and tested. But to how many of you, to how many people in the world, can we give a diploma which will certify that they are emotionally grown-up and entitled to the privileges of independent people? Not to the jealous, the envious, the suspicious, for these people haven't passed third-grade requirements. Not to chronic worriers or drinkers. Not to the selfish and disagreeable. Not to the graduate of any

school who cannot eat a meal unless it is cooked by her mother. Not, Miss Nelson says, to John Ruskin, who at fifty-two was ruled by his mother, who had previously accompanied him to college and chosen a wife for him. Perhaps to Benjamin Franklin. Certainly to some college graduates who have taken special courses in a sanitarium, finding out, for instance, that it isn't wrong to be happy, or that it is well to establish some regular habits from which imagination can take flight and on which it can find a landing place, or to develop a capacity for independent and unprejudiced actions.

It will not do to call attention to the mental troubles to which all are heirs without suggesting what can be done to avoid or cure them. It goes without saying, if one has thought at all about the matter, that in general we must support schemes for better emotional training. We must get a plan into it. Undoubtedly some of the trouble comes from introducing a soft baby into a hard world, and some of it cannot be helped. But a soft baby has a wonderful capacity to learn which ought to call out in adults a corresponding ability to teach. Wherever long-distance plans have been tried, they have met with gratifying success, even when started admittedly rather late. The person to whom a mother gives the care of an infant should be some one with better intelligence, training, and taste than her own. If we feel humble enough about our adult teaching ability, we have taken one step ahead.

Methods of reaching the prejudices of everyday life are fortunately at hand, thanks to the experience with delusions. The avoidance of direct attack is fundamental; arguing fixes the belief. The discussion of the foundations of beliefs in general has a good effect. The indirect practical attack has been illustrated by Dr. Watson. The baby prejudiced against a toy rabbit came to accept it when it was introduced under pleasant surroundings, first at a far end of the room and then nearer and nearer. Of course it is difficult to manage such treatment in surroundings more complicated than those of the laboratory. But it seems to me that many people who years ago protested against modern dress have been cured in some such manner, and it might be suspected that some one had been arguing with those not yet reconciled.

Another indirect attack is the occupational. The wished-for outcome is illustrated by the remark, "I was so interested in working for them (or with them) that I forgot that I did not like them." This policy is broadened in an effort to get prejudiced persons into the habit of making new mental combinations all the time. New interests and ideas as they change seem to make old sets, old attitudes, change in sympathy—or to drain off some of the emotion that is behind the prejudice.

If one were trying, for some selfish political end, to intensify the prejudices of a community, one would argue about them, pro and con, while encouraging idleness, provincialism, and the settled habits of a premature old age with its unwillingness to consider new ideas.

There is a longer and more difficult remedy for prejudice and uncontrolled emotions to be considered—the attempt to run to earth the past experiences that keep you happy, or unjust, or jealous— that keep you from being "free and twenty-one". It consists in a laborious review, with doctor and patient working together, of that curious mental life of ours which runs alongside of our more sensible thinking—where dreams, superstitions, and symbols run riot. It means trying to recover and to uncover events of childhood which we handled badly, or solved at a fairy-tale level—to live them over again in the light of our adult experiences. This is psychoanalysis, long and expensive—eight weeks at the least and years at the worst—applicable to some people and some situations and not to others. Many of its difficulties are evident; we have forgotten so many of the origins of our attitudes, our fears, and our conclusions, and the further we go back, the harder it is to find the right words—for our words have changed with our times. In all this exploration mental patients are of great help; they are almost "contemporary ancestors" of ours; they often get directly to a life and thought hidden from well people; they are what we were; they can tell us how differently their minds work when they are sick and when they are well. And psychiatrists, after analyses, after the study of mental diseases, may make suggestions for the better guidance of everybody's education and problems, so that many can gain without paying the cost, either of a struggle to get at what they do not wish to face or of mental disease.

But can I see geniuses going into the world without asking them to give a thought to these things? Psychiatrists play a small part in the world; but I hope that you see why psychiatrists must do two things—look after their patients and pass along the lessons learned from them to the most normal and most gifted people they can find.

PROBLEMS PRESENTED AND RESULTS OF TREATMENT IN 150 CASES SEEN AT THE HABIT CLINIC FOR PRE-SCHOOL CHILDREN IN BOSTON *

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THIS study was undertaken with the purpose of determining what problems confront us most frequently. We hoped to learn, if possible, the results of the treatment outlined, and in this accounting to draw conclusions as to the causes of success or failure that would help us in formulating further plans for individual therapy and in the general development of our work.

The 150 cases reported on in this group were selected from the first 300 seen in the Habit Clinic in Boston. All of the cases had been known to us for two years, and in some instances five years had elapsed since our first contact. Some of the 300 had to be eliminated because there was too little information on them to be of value in this study, while, in spite of careful search, many of them could not be located. This follow-up study after a period of years was a particularly difficult task because of the fact that in the early days of our development, our intake of patients came largely from the thickly settled tenement districts where the population shifts rapidly and where contact with the families is easily lost.

To obtain the information with which to check up progress, a visit to the home was made in each case. The purpose of the study was explained to the parents and the facts were brought out by direct questioning. In every instance an

* The material used in checking up progress in these cases was obtained by Miss Dorothy Stebbins in 1927.

TABLE 1.—CLASSIFICATION OF PROBLEMS PRESENTED IN GROUP OF 150 PRE-SCHOOL CHILDREN.

Type of problem	*Number out of 150 cases.*	*Satisfactory improvement when clinic contact ceased.*	*Unsatisfactory improvement when clinic contact ceased.*	*Satisfactory at time of follow-up.*	*Unsatisfactory at time of follow-up.*	*Short-time case.*	*Intensive case.*	*Physical environment* *Coöperative parents.*	*Uncoöperative parents.*	*No resources.*	*Fair resources.*	*Adequate resources.*
Faulty food habits.....	61	26	35	33	28	50	11	30	31	11	42	8
Enuresis.....	56	32	24	43	13	40	16	38	18	21	34	1
Temper tantrums.....	50	12	38	20	30	35	15	22	28	20	29	1
Disturbances of sleep.....	34	17	17	25	9	24	10	20	14	12	21	1
Disobedience.....	27	10	17	14	13	19	8	13	14	10	16	1
Disturbances of speech.....	25	7	18	15	10	20	5	16	9	11	13	1
Masturbation.....	23	15	8	17	6	17	6	16	7	9	14	0
Thumb sucking.....	20	6	14	13	7	16	4	8	12	8	12	0
Pugnacity.....	15	3	12	7	8	9	6	7	8	6	8	1
Hyperactivity.....	12	2	10	5	7	6	6	4	8	2	9	1
Nail biting.....	10	7	3	8	2	8	2	8	2	3	5	2
Soiling.....	10	4	6	10	0	7	3	6	4	5	5	0
Jealousy.....	9	2	7	6	3	6	3	6	3	3	6	0
Crying spells.....	9	8	1	9	0	4	5	8	1	2	6	1
Overattachment.....	8	4	4	6	2	2	6	6	2	1	6	1
Irritability.....	7	3	4	3	4	5	2	2	5	2	4	1
Shyness.....	7	4	3	7	0	4	3	5	2	3	4	0
Fears.....	7	3	4	3	4	3	4	5	2	2	5	0
Destructiveness.....	6	0	6	1	5	2	4	2	4	4	2	0
Truancy.....	5	3	2	3	2	4	1	3	2	3	2	0
Excitability.....	5	2	3	2	3	3	2	3	2	1	3	1
Stealing.....	5	3	2	4	1	2	3	3	2	3	2	0
Lying.....	3	2	1	2	1	1	2	2	1	1	1	1
Negativism.....	3	2	1	2	1	3	0	2	1	1	2	0
Daydreaming.....	3	3	0	3	0	0	3	3	0	2	1	0
Limp spells.....	3	2	1	2	1	2	1	1	2	1	2	0
Personality change.....	2	0	2	2	0	1	1	2	0	0	2	0
Neurotic vomiting.....	2	2	0	2	0	0	2	2	0	1	1	0

attempt was made to learn the present status of the problems for which the child had been brought to the clinic and to discover to what factors the parents attributed their success or failure in dealing with these problems. The majority of them remembered the clinic experience well and were friendly and interested in the project.

In our effort to make clear the data obtained from the study of these cases, we have analyzed the material under the headings "Type of problem", "Satisfactory or unsatisfactory improvement", "Short-time or intensive case", "Parents coöperative or uncoöperative", and "Physical environment" (see Table 1, page 530). It seems advisable at this point to give some further explanation of these groupings.

Under "Type of problem" we have recorded 28 different kinds of problem, all of which appear more than once among the children seen. Some are the problems that caused their coming to the clinic, while others are those found after analysis of the case.

We found it necessary to record improvement under two subdivisions. The first is "Satisfactory improvement when clinic contact ceased". By this we mean a good response on the part of child and parent at the time contact with the clinic was closed, this response being definitely attributable to the advice and suggestions obtained. The second, "Satisfactory improvement at time of follow-up", refers to the status of the problem at the time of the follow-up visit, whether attributable to clinic contact or not. With the first group, some slipped back after contact ceased and at follow-up appear among those considered unsatisfactory, while some of those at first considered unsatisfactory later responded and appear in the satisfactory group at the time of follow-up. In no problem group, however, was the number with satisfactory adjustment at the time of follow-up less than the number at the close of the clinic contact. In the majority of instance, it was larger.

We call "short-time" cases those that involve less than five visits to the home by the social worker. "Intensive" cases are those having more than five social-service or clinic

visits and that may require repeated visiting in order to change attitudes and adjust the social environment.

The parents' response is listed as "coöperative" when sincere interest and effort are indicated. In the situation of a child with several difficulties, the parents may be entirely coöperative in dealing with one phase of behavior and utterly unwilling to work with us on another. This is given consideration, and coöperation is recorded in relation to the particular habit or difficulty, not to the situation as a whole.

Under the heading "Physical environment", the economic situation and physical condition of the home is considered and is classified as "no resources" within the home for normal growth and self-expression, "fair resources", and "adequate resources".

In Table 1, the various problems found in these cases are listed in the order of their frequency. This tabulation brings out some interesting material. We find that faulty food habits make up the largest group of problems, appearing in 61 of the 150 children under study. The proportion of improvement obtained is, moreover, rather low. Only 26, or 17 per cent, were considered satisfactory at the time clinic contact ceased, and 33, or about 55 per cent, at the time the follow-up visit was made. Of the 61 cases, 50 are in the short-time group, while the number of parents who coöperated and of those who did not are nearly equal. Under "Physical environment" an interesting fact appears—42 of these cases came from homes with "fair resources" and 8 from homes with "adequate resources". In no other problem are there more than 2 under the latter heading.

Neurotic vomiting was found only twice among the feeding difficulties, and each case cleared up early and maintained the improvement. Both were intensive cases, and the parents coöperated well.

Children with enuresis or incontinence of urine, either during the day or at night, make up our second big group. We find that 56, or 37.3 per cent, of the 150 had failed to establish dry habits and were, therefore, brought to the clinic. Improvement with this problem is decidedly more common than in the case of the feeding difficulties. When clinic contact ceased, 32 cases showed satisfactory improvement, and at

the time of follow-up, 43 had overcome the habit. The greater number were short-time cases. In just over two-thirds of the group was there good coöperation. An investigation of the physical environments of these cases showed that all but one came from limited and inadequate homes.

The problem of soiling appears less often, yet it seems logical to consider it at this time. We find the habit occurring in only 10, or .06 per cent, of the 150 cases. In 4 we obtained immediate improvement, and at the time of follow-up the difficulty had in all instances been entirely eliminated, even though 7 of the group were short-time cases. Good cooperation was given by the parents in 6 cases, and the 10 children came equally from homes of no resources and of fair resources.

The 50 cases of temper tantrums make up the third largest group. Only twelve of these were satisfactory when contact ceased and only 20 at the time of follow-up. Fifteen were intensive cases, and in 22 parents were coöperative. The environments, as in the case of practically all the other habits to be mentioned, are listed for the most part in the two least favorable classes.

We often find the child using crying spells and so-called limp spells as well as temper tantrums to express anger or to dodge an unpleasant situation. Nine of our group had frequent crying spells. Of these 8 improved at once upon treatment, and all had given up the habit by the time the follow-up visit was made. Intensive work was done with 5 of the cases, and in 8 of the 9 the parents were wholly coöperative. The so-called limp spells appear only 3 times, and 2 of these cases improved readily.

With the 34 cases of disturbances of sleep we obtained good results. Seventeen had improved satisfactorily when clinic contact ceased, and 25 at the time of follow-up, and this in spite of the fact that 24 were short-time cases. Parents were coöperative in 20 cases. Twenty-one of these children came from homes of only fair resources, and 12 from the most limited homes, where sleeping arrangements were congested and unsatisfactory.

General disobedience, or lack of training and discipline, brings us many children throughout the year. Twenty-

seven of the present group came for this reason. Ten responded immediately to the routine outlined, but only 14 were found to be improved at the time of follow-up. The greater proportion were short-time cases. Parents were coöperative in 13 cases and uncoöperative in 14.

Among little children we often find disturbances of speech. This problem came up in 25 of the 150 cases. At the time of follow-up, 15 had definitely improved. Coöperation was good in 16 cases.

Auto-erotic habits do not appear with great frequency in the group under study. Masturbation was observed in 23 cases, thumb and finger sucking in 20, and nail biting in 10. Suggested treatment for masturbation brought quick response in 15 cases; thumb sucking was decidedly slow to show progress, only 6 being improved when clinic contact ceased; while nail biting responded rather readily to treatment and, at the time of follow-up, all but 2 of the 10 cases had given up the habit entirely. Parents coöperated well in 8 of the 10 cases of nail biting and in 16 of the 23 cases of masturbation, but in only 8 of the 20 cases of thumb sucking was the advice given really carried out.

Truancy, stealing, and lying were rare in this group. Cooperation was good in these cases, and they responded well to the suggestions outlined.

Of the exaggerated personality traits, we see most often the pugnacious, hyperactive, excitable, irritable, destructive, extroverted type of behavior, yet in less than half of these cases did we get good coöperation from the parents and less than half showed ultimate improvement.

The introverted, shy, daydreaming, fearful, and negativistic child is brought to the clinic infrequently, but those that appeared in the group under study responded well. Of the 7 shy children, 4 improved while in contact and all 7 by the time of follow-up. Coöperation was readily obtained. The 3 daydreamers dropped the habit during an intensive and coöperative contact, even though 2 came from homes of the most meager type where substitution of interests was particularly difficult. The negativistic conduct changed after the carrying out of the suggestions given. With the fears of childhood, improvement was not so great. Of 7 children,

only 3 overcame their difficulties, though 5 parents were ready and willing to follow the advice given.

Jealousy and overattachments were found in 9 and 8 children respectively. In both these situations, improvement was good. Six of the jealous children responded to coöperative treatment, and 6 of the overattachments dropped back to apparently normal relationships.

Of the 150 children studied, only 2 appeared to have so-called "personality changes" subsequent to illness. Both of these made a slow readjustment; in both instances the parents were entirely coöperative.

From the material presented, we find, as might be expected with a pre-school group, that the problems we are most frequently called upon to treat are those relating to the establishment of the fundamental physical habits of eating, sleeping, and eliminating, and also those that develop during the general training and discipline of the little child.

Some may feel that these problems are of minor importance and will be outgrown, yet often we find the more spectacular and involved personality difficulties developing from these uncorrected simple situations. It is in the training for these first habits that the pattern of later conduct is laid, and the child early learns to adapt to a wise routine or finds that he himself can control the situation. Take, for instance, faulty eating habits. The difficulty is not that the child is having too little nourishment, but rather in the way he is using his caprices of appetite to terrorize the family into submission to his will. With enuresis, beyond the obvious unpleasantness of a wet bed, the habit may be far reaching in its effect upon the personality. If continued beyond normal babyhood, it stamps the child as different and tends to build up feelings of inadequacy and inferiority. Frequently the burden of the extra washing upon an already overtaxed mother so increases the emotional tension of the home that the comfort and happiness of the whole group is jeopardized. In the matter of discipline, if the child early learns respect for just authority, emotional control, and self-reliance, he should be well equipped to make the adjustments necessary when he leaves the shelter of the home and enters upon his larger community contacts.

Beside the major habit problems, we find somewhat smaller numbers of the various personality traits that are normal to all of us in some degree, but that have become exaggerated and are causing difficulty for the child in his social adjustment. It is quite evident, from this as well as from other studies of clinic material, that the child who comes to the clinic most often is the one whose extroverted tendencies have brought him into conflict with his environment. The passive, withdrawing traits cause little concern to the parents at this age and appear in comparatively few instances in this group of 150 children.

When dealing with personality development and modification of behavior, evaluation of results is necessarily difficult. In the case of the material under study, to take as an estimate of successful treatment the number of cases considered improved when clinic contact ceased would give us a misleadingly low figure. Parents often lose touch with the clinic before results could be expected from the treatment, and if evaluated at that point, the case would have to be considered unsuccessful; whereas these same parents, having obtained an outline of treatment, may consistently carry it through and definitely attribute their success to the help they gained from their clinic contact. In cases with longer contacts, improvement often comes slowly, upon the gradual assimilation and putting into operation of the advice received. On the other hand, if we take the number improved at the follow-up visit, we may have a somewhat inflated figure because of the lapse of time that has occurred. This time element must be considered, for we know that children pass through phases of conduct probably normal to their age, and the mere act of growing older has, in all probability, in some instances helped to eliminate the problem, as with a negativistic trend, mild masturbation, or thumb sucking. In general, however, the number that show ultimate improvement should be considered as the criterion of treatment success, for, if there has been a contact with the clinic, that undoubtedly plays some part in the recovery, even though the time element enters in as well.

Although we have considered our therapy adequate only when two-thirds or more of the children presenting a certain

problem have improved satisfactorily under treatment, yet in the case of 10 of the problems, we found decidedly more than two-thirds responding, and in the case of 5, all the children showed complete improvement.

Our greatest proportion of successes came with neurotic vomiting, soiling, crying spells, daydreaming, and shyness, all of which showed complete improvement at the time of follow-up. One may here ask why this particular group of difficulties should have responded in such a marked degree. Undoubtedly the emotional attitude of the mother plays a large part in the response in the case of the first three of these habits. They are spectacular, embarrassing, and annoying to the parents and arouse their concern and their desire to coöperate in a plan for treatment. The last two being passive and less irritating traits, it is rather surprising to find so large a proportion of improved cases. It seems only reasonable to suppose that the time factor has played a part here, particularly in the improvement of the shy children.

Enuresis and sleeping difficulties are the two largest groups to make satisfactory improvement. Enuresis is another unpleasant and inconvenient habit; parents are eager for help with it and considerable pressure is brought to bear to overcome the difficulty. With both enuresis and sleeping difficulties, a rather definite routine and schedule can be outlined, which makes the carrying out of instructions quite simple. On the other hand, with faulty food habits, the largest problem group, we find just over one-half of the cases showing satisfactory improvement, even though a clear routine is laid down for treatment. Two factors must be considered here. In the first place, physical gain is so closely related to intake of food that many parents become panicky and upset over the child's failure to eat three large meals a day, with the full quota of milk and vegetables, and the child is only too quick to sense this and capitalize it to his immediate advantage. In the second place, the mere waiting on the little child is often such a satisfaction to the mother that she may unconsciously cling to the child's dependence. The bottle is given longer than necessary, the child is spoon-fed instead of learning to feed himself, and a hard-hearted régime of pleasantly ignoring the child and removing the

uneaten meals with no comment may actually be beyond the parents' emotional ability.

The problems with which we have the least success in treatment are the feeding difficulties, as just mentioned, the extroverted personality traits — such as pugnacity, hyperactivity, temper tantrums, destructiveness, and disobedience— and the habit of thumb sucking. This last mentioned habit shows conspicuously both lack of success and lack of interested coöperation. Only rarely do the parents express great concern or show persistent desire to overcome the difficulty. In fact, we find children deliberately taught to suck their thumbs to keep them quiet, or encouraged to continue because they look "so cute".

With the personality traits, it is not surprising that we do not have a larger proportion of successes. For one thing, even with the professional group, the subject is not clearly defined as yet. Who can say what is inherent in the make-up and what is built up from without? Who can make a dogmatic prognosis as to the outcome if these traits are allowed to grow unchecked? We may theorize and speculate and probably may come fairly close to the mark, but we must be able to back up our theory if we are to convince parents of the ominous trend of some of the situations we see developing. Then, having convinced them of the need and won their desire to coöperate, we must be ready with a workable plan of treatment. Here, again, we find it difficult, for each situation varies; no easy routine suggestions can be laid down and results depend much more upon the parents' own initiative and resource. For instance, a hyperactive and destructive child may need freedom from restriction, plenty of muscular exercise, the development of new interests, and so on. Yet, if his setting happens to be more confining than the often desired "ten-acre lot", what then? Neighbors' property and rights must be respected, traffic and other dangers must be avoided, and usually the mother's attention must be divided among several children and the business of homemaking. It takes abundant physical energy and clever planning ability so to organize a situation of this type that the child will develop new interests, will have sufficient outlet without license, and yet that the home and the other children

will not suffer in the process. Like difficulties occur with temper tantrums and pugnacity. Often the simple treatment of allowing the child to shriek out his temper spells and obtain nothing thereby may bring the family a notice to vacate. Or if it is suggested that a pugnacious little rascal be allowed to continue his fights, in the hope that an attack upon a stronger child may teach him the lesson he so badly needs, the neighbors may rise up in objection and the parents may then feel that they must abandon the method, and yet lack the imagination and the originality to devise some substitute. More intensive work by the clinic staff, in explaining the need and in helping the families over a longer period of time to work out means to bring about the desired ends, would without a doubt raise the proportion of successes with these difficult and intangible personality traits.

The proportion of improvement made bears a close relation to the degree of coöperation obtained, as may be seen in Table 2. It seems evident that where a concrete régime for treatment can be laid down and where a marked emo-

TABLE 2. RELATION BETWEEN IMPROVEMENT AND COÖPERATION IN 150 CASES OF PRE-SCHOOL CHILDREN

Problem	*Total cases*	*Improved cases*	*Coöperative cases*
Faulty food habits	61	33	30
Enuresis	56	43	38
Temper tantrums	50	20	22
Disturbances of sleep	34	25	20
Disobedience	27	14	13
Disturbances of speech	25	15	16
Masturbation	23	17	16
Thumb sucking	20	13	8
Pugnacity	15	7	7
Hyperactivity	12	5	4
Nail biting	10	8	8
Soiling	10	10	6
Jealousy	9	6	6
Crying spells	9	9	8
Overattachment	8	6	6
Irritability	7	3	2
Shyness	7	7	5
Fears	7	3	5
Destructiveness	6	1	2
Truancy	5	3	3
Excitability	5	2	3
Stealing	5	4	3
Lying	3	2	2
Negativism	3	2	2
Daydreaming	3	3	3
Limp spells	3	2	1
Personality changes	2	2	2
Neurotic vomiting	2	2	2

tional factor in the parent-child relationship is not present, coöperation is readily given. The extent of the coöperation must necessarily depend upon interest, intelligence, emotional stability, and the physical and economic condition of the parents. We frequently find parents who are aware of their difficulties and apprehensive for the future, yet the sheer pressure of caring for a family on their narrow margin of income and physical energy makes them utterly unable to coöperate in treatment. On the other hand, we find parents who, in spite of almost overwhelming social problems, can carry out a treatment routine in such a way as to call forth our sincere admiration. We feel sure that if more time were given to the individual case, particularly by the social worker—who has an invaluable opportunity to interpret over and over again in detail in the home the recommendations given at the clinic—coöperation might be obtained in a greater proportion of cases, as failure to coöperate often means merely failure to understand.

This study includes cases seen in our first four years of development, when for many reasons we might have expected only a small degree of success. The Habit Clinic was started as an experimental project, the general public had little knowledge of the venture, and even the staff was unconvinced of the practicability of the plan. Our technique was in the making and only vaguely defined, and few routine measures were in use. The majority of our clients came from families already known to several other social agencies and presented the most involved economic and sociological problems, making the working out of a mental-hygiene program exceptionally difficult. Yet in spite of these handicaps, our therapy proved adequate for more than half of the problems we were called upon to treat. A study of cases taken from those seen in the last two years would unquestionably show interesting comparisons. As the work has developed, our confidence in our technique has grown and in many situations we now feel that we can safely be dogmatic in outlining treatment. Also we are reaping the benefits of the general educational work in mental hygiene. Many of our patients are now brought to us by parents who have heard or read of the service given and are seeking help; others come at the suggestion of those

who have already made a clinic contact; and a third large group comes through the efforts of workers in other social agencies who have an intelligent understanding of our purpose and explain it to the families before suggesting that they seek help. All this, of course, will make for better understanding of the treatment suggested and coöperation in carrying it through, and should greatly increase the proportion of improved cases.

We may, then, conclude from the facts brought out by this study that in the early cases seen, our therapy has been adequate with the greater number of habit problems. We do, however, need to develop more carefully our technique in dealing with the asocial personality trends. The key to the situation in each instance seems to be in coöperation, which in turn largely means understanding. Therefore, more time must be given by the staff to detailed instruction and the effort to make the treatment suggestions more clear and concrete. Especially, more of the time of the social worker should be available for intensive case-work. Above all we should develop our individual educational approach, for mental-hygiene work with little children must necessarily be that of parental education. We may at the clinic offer advice and suggestions based on our detailed study of the child, but it is our part also to make the parents understand the value of such advice before we can expect a satisfactory response to treatment.

ANTISOCIAL ATTITUDES, THEIR FORMATION AND REFORMATION

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NOT long ago Freud startled the world by stating that criminal tendencies can be discovered behind the conscious surface of highly respectable and ethical persons. Freud was followed by Adler, Jung, and Stekel, who brought confirmatory evidence that criminals are made by the emergence and overstimulation of the same kind of tendencies that are inhibited by persons who had the good luck to live in an environment that favored the formation of socially desirable attitudes.

The contribution of these writers to the problems of the cause and cure of crime can now be studied in the translations of their books. But this is not true of the two most important contributions to our subject made recently in Europe. I refer to the work of Rank and Aichhorn, whose books have not yet been translated into English. Rank has made clearer the causes of antisocial behavior, and so makes clearer the way to prevent its formation. Aichhorn has shown how the most unpromising adolescent delinquents can be cured by a method built on the new knowledge.

In his *Outlines of a Genetic Psychology*[1] Rank shows the chief stimuli that cause the emergence of abnormally strong passions or emotional drives and criminal habits. In his *Neglected Youth*[2] Aichhorn shows how the already formed delinquent habits may be broken and replaced by socially safe behavior.

To take Rank's theoretical contribution first, it is the clearest account I can find of the genesis and growth of emotions or feelings. Rank traces the roots of love and hate

[1] See *Grundzüge einer Genetischen Psychologie*, and *Gestaltung und Ausdruck der Persönlichkeit*, by Otto Rank. Leipzig: F. Denticke, 1927 and 1928.

[2] *Verwahrloste Jugend; die Psychoanalyse in der Fürsorgeerziehung*, by August Aichhorn. Leipzig: Internationaler psychoanalytischer Verlag, 1925.

back to the time of earliest infancy. Freud saw that the first five years of life are the most important for the formation of character, but he stressed the later period from three to five years, when the father begins to take an important part in the making of the child's ego ideal. Like Watson in this country, Rank stresses the earlier period and the rôle of the mother and the nurse in conditioning healthy and socially acceptable emotional responses.

Some roots of later crime are found deep in the nursery period, in babyhood. At the school period it is too late to begin the search for the causes of antisocial attitudes. Even before the Œdipus phase, as Freud calls it, there is guilt and the beginning of an ego ideal. The child is innately built to respond to the prohibiting mother. Rank is compelled to assume an inborn tendency in the human being to check or inhibit innate impulsive drives. Too little inhibition means the prolongation of infantile irresponsibility to form antisocial or perverse activity; too much inhibition means neurotic ill health or waste of energy in ascetic self-torture. It largely depends on the parents', and especially on the mother's, behavior whether the child can avoid these morbid extremes of antisocial activity or passivity and develop a healthy capacity for love and work.

There are two ways in which the mother can promote healthy and socially desirable habits in the child. First, she can avoid an immoderate satisfaction of the child's love hunger and a needless arousal of resentment and hate. Second (if she is not too full of character kinks and emotional distortions) she can find the mean between the dangerous extremes in her discipline and training of the infant and child. "Spoiling" the child by too much love and leniency is less likely to produce crime than is loveless aggression or hypermoral coercion. If the child lacks sufficient external checks upon its impulses, it is apt to build excessive inhibitions in its conscience, often becoming neurotically self-critical. But if it feels too much the mother's prohibitions as hate, it may form the habit of resentful rebellion against authority and later displace this hate from its parent to its schoolteachers, to social restrictions, and to national laws.

We all know the relief we get by expressing emotion. It

makes us feel better, when enraged, to hurt something, even though the person or animal we hurt is not the cause of our rage. If anger and hate have been overstimulated in the child, it is often impossible for it to act these emotions out on its parents. Either it lacks the bodily or mental power to fight, or it also loves the hated tyrants, and so cannot get rid of its festering accumulation of morbid emotion. Consequently (as Rank shows) the child generally seeks relief for its pent-up feelings against mother, father, or rival child by means of aggression outside the family circle. Occasionally, indeed, the child kills its baby rival or even its parent, like Dorothy Ellingson, but usually it displaces its hate, like Hickman, from its own sister to the child of other parents, or, like Raskolnikov, to a mother substitute, or, like the anarchist assassin of royalty, to a father substitute.

The seeds of crime may be sown not only by really loveless parents, but also by really loving parents when they seem hatefully unkind to the child. This is not the place to give detailed information as to the latest theory of child training in habits of love and social adjustment. All I can do is to assure the reader that some very definite principles have now been worked out as a guide to parents and nurses in the difficult and delicate task of developing healthy emotions and socialized action patterns in the child. The inquirer is referred to an article by the writer in *Better Health*, December, 1928, entitled *Helping the Child to Bear Life After Birth* and to the pamphlets on the subject published by The National Committee for Mental Hygiene.

Here I may refer to another new and paradoxical discovery about the complex motives for crime. Some persons (as Reik shows in his book on the need for punishment) commit crime not only to get an outlet for hate, but also to get relief for an intolerable guilt feeling. A case of schoolboy naughtiness will serve to illustrate this strangely inverted mechanism as a factor in misbehavior. This boy was working with a psychologist for the purpose of getting an emotional adjustment. He confessed that at school he used regularly to do bad work in class and behave badly in order to be punished by his teacher. The teacher, knowing nothing of the boy's need, fell into his trap and spanked him

thoroughly. No doubt the teacher made a moral justification for his method of discipline which actually stimulated the habit of hate in the boy for the teacher and for himself.

This case leads me to the further striking evidence that Aichhorn has collected on this very point. As the principal of a reform school for delinquent adolescents of both sexes, Aichhorn had an opportunity to apply some of the new theories with regard to the emotional factors of delinquency. He was convinced that these wild, neglected, and antisocial youngsters had become delinquent through lack of love at home. He, therefore, decided to try the experiment of providing a substitute for home and for parental sympathy, understanding, and guidance. Accordingly he obtained as assistants teachers who were willing to avoid all corporal punishment.

This policy demanded an extraordinary amount of patience and perseverance, which came only from a strong belief in the correctness of the hypothesis to be tested. The youngsters tried in every possible way to maintain the habit of hate, aggression, mistrust, and rebellion against the authorities. To this end they made constant efforts to cause teachers and principal to lose their temper and answer their hate by hate, for violent disciplinary measures would have justified their continued revolt. But at length — the time varying according to disposition and intensity of emotion — Aichhorn's policy of sympathetic understanding and patient forbearance triumphed.

From several very instructive cases in Aichhorn's book I will choose two that show most clearly the emotional factors in antisocial attitudes and indicate the method of cure. The first is that of a thirteen-year-old boy who constantly stole from his mother and sister. This boy hated his mother for having had his younger sister, who robbed him of his power and freedom as the only child. His anger was increased when his mother seemed to love his sister more than him by giving her more money. To express his hurt and hate, he ran away from home, but his love made him seek cherries from his father's orchard trees to bring back as a guilt offering to his offended mother.

The second case is a young fellow who was sent to Aich-

horn because he used to steal from his very strict father. With the money thus gained, he used to give presents to his stepmother, who was not much older than he. The first interview with Aichhorn (part of which I reproduce) shows clearly the emotional need of the boy and the way in which it can be satisfied by one who has insight. In order to gain a rapport, Aichhorn asks: Do you know where you are?

The boy: No.

Aichhorn: In the office where adolescent cases are dealt with.

Boy: Yes? Yes, my father wants to put me in a reform institution.

Aichhorn: Your father has told me all that has happened, and I want to help you.

Boy: That is good. (*With a look of complete refusal and a shrug of the shoulders.*)

Aichhorn: If you don't want me to, then I surely won't.

Boy: You can't help me.

Aichhorn: I understand: you don't trust me; we are still too strange to each other.

Boy: I don't mean that, but it's no good. (*Again the same gesture of refusal.*)

Aichhorn: Are you willing to talk to me?

Boy: Yes, why not?

Aichhorn: I must ask you about various matters, and for that reason I am going to make you a proposal.

Boy (*in an expectant tone*): What about?

Aichhorn: To refuse me an answer to every question that is unpleasant to you.

Boy (*with astonishment and incredulity*): How do you mean?

Aichhorn: To the questions you don't want to answer, you may be silent if you like. You can also say to me that that is none of my business.

Boy: Why do you allow me that privilege?

Aichhorn: Because I am neither a judge nor a police agent. It is not necessary for me to know all. And because in any case you would not tell me the truth about unpleasant questions.

Boy: How do you know that?

Aichhorn: Because no one would do so, and you are no exception. I myself wouldn't tell everything to a man whom I had never seen before.

Boy: But if I speak to you and lie to you, can you tell that I'm lying?

Aichhorn: No; but it would be a pity to do it. And you don't have to, because I won't compel you to answer me.

Boy: At home they always said to me nothing would happen if I spoke the truth, but when I did, it always made matters worse. So I've accustomed myself not to talk.

Aichhorn: Here it is a little different. What you really wish to say will be enough for me. Certainly I must be sure that I shall not hear what is untrue.

Boy: Good.

Aichhorn: You agree, then? (*Holds out his hand to the boy, who grasps it strongly.*)

Boy: Agreed.

Having won the boy's confidence, Aichhorn was now able to discover the reason for his running away from home and stealing his father's money. His brother had been able to go with his mother to stay with an aunt abroad, while he had to stay on the job as a shoemaker at home. His father had given his brother some money for the trip. So he felt he had a right to take some money and give himself a trip as a compensation.

After interviewing the father, Aichhorn saw that the strict and emotional parent was unable to educate the emotionally hurt son. Aichhorn, therefore, arranged a series of meetings with the boy in the city. One evening, as they were walking towards Aichhorn's home, the boy remarked: "If my father behaved to me as you do, I should never have done all these things." The association was gradually broken off when Aichhorn saw that his aim was accomplished, and the father reported that the son was as good as ever before. Three years after that (at the time the book was written) no relapse had occurred.

Without love the reëducational process cannot begin. Sometimes Aichhorn was able to rouse the right attitude by means of an emotional shock. For example, a young narcissist only stayed in the institution when it seemed less pain-

ful than the world outside. This boy was uneducable for lack of what the Freudian calls a transference. One day Aichhorn purposely provoked the boy to run away. After nine days he returned, expecting punishment. Without even a reproach, Aichhorn looked at him and asked if he was hungry. Finding that he was famished, Aichhorn took him to his own dining table, but the boy was too amazed at the absence of hate in Aichhorn's attitude to be able to eat there. So he went to the kitchen. At ten Aichhorn remarked that it was too late for him to go to sleep with his group that night, and, stroking his head, offered him a couch in his home and wished him good night. Next morning the boy showed his belief in the principal as the "good mother" substitute; and soon after this his reëducation progressed so well that this thief and swindler could safely be trusted to bring an auto full of stores from Vienna to the school without stealing a thing. Later he did well in a big business establishment. Punishment would have fixed his hate in a life of continual crime.

One day Aichhorn had been reading Rank's theory and decided to test it on an eighteen-year-old thief. He put him in the tobacco store. The cashier soon reported a theft. Aichhorn called the thief into his study and asked him to help in dusting the books, and at intervals asked questions about his work. The boy's anxiety and suspense grew almost intolerable. Finally in answer to a direct question he confessed. Not a word of blame from the principal, who gave him the sum and told him to put it back in the cash box so that no one would know of his deed. The boy was so touched that he not only stole no more, but asked to be allowed to pay back his debt.

Aichhorn's policy demanded most patience with the small group of violently aggressive adolescents, who had all suffered from unloving parents and had been corporally punished at home. When one attacked another with a knife, the refusal of Aichhorn to interfere so maddened the attacker that he threw his knife on the floor, stamped with rage, and uttered a bellowing which turned into the most violent weeping and finally ended in sleep from exhaustion. Such scenes were repeated with each one of this worst group, the rages

growing less and the behavior better, until they became a homogeneous group in rapport with the teacher. Then gradually more restrictions were imposed, preparing them to bear the hardness of life.

The conclusion to be drawn from this evidence is clear. All who value mental and moral health should work for the day when parents, nurses, and teachers, as part of their regular preparation for their duty, will take a course in ego education and emotional adjustment from one who is trained in one or other of the various technical methods that have been devised for this purpose. Until the state or nation adopts this plan as part of the educational scheme, the task must be shouldered by the pioneers in the mental-hygiene movement.

ATTITUDES AND EDUCATIONAL DISABILITIES

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IN a recent study of reading disabilities,[1] some of the relationships between that particular type of educational disability and the emotional reactions of the child were described. In the present report, the primary concern is with emotional attitudes as causes of disability in reading or arithmetic, and as barriers to successful remedial teaching. As in the previous paper, our material is too limited to be subjected to statistical treatment. This is probably not much of a handicap, however, as the problem is one that is better adapted to the case-study method of investigation.

There have been several statistical studies, in our clinic and elsewhere, which indicate that the emotional conflicts and the personality and behavior deviations of childhood do not necessarily interfere with educational achievement.[2] Exceptions to this rule occur when the emotional reaction becomes specifically associated with the study of some particular subject or subjects—with the learning situation.[3] At least this seems to be the case so far as one can judge from intensive individual case studies.

The literature on educational disabilities has occasionally referred to this possibility. Dr. Meek, while studying the initial reactions of children to the first tasks in reading, observed that pupils who failed not only lost interest in it, but showed decided dislike to it and refused to put forth

1 *Reading Disabilities in Relation to Maladjustment*, by Phyllis Blanchard. MENTAL HYGIENE, Vol. 12, pp. 772–88, October, 1928.

2 For a review of the literature on this point, see *Educational Achievement of Problem Children*, by Richard H. Paynter, Jr. and Phyllis Blanchard. New York: The Commonwealth Fund, 1929.

3 This statement is not intended to convey the meaning that there are no other exceptions.

further effort.[1] Gates, commenting upon Dr. Meek's report, makes the following statement: "Had such conditions been permitted to continue, the result would doubtless have been, in time, a serious 'disability' in and hatred of reading. Doubtless, many 'disabilities' in reading arise in just this way; perhaps some of them originate in the very first lesson."[2]

Elizabeth Hincks, reporting a series of case studies to show the relation between reading disabilities and personality traits, mentions the probability of emotional factors in etiology in some instances. For example, of one boy she says: "Reading naturally had acquired an association of unpleasantness, since it was done with a father who exploded with anger every time the boy made a mistake." Miss Hincks concludes that many of her subjects "showed lack of interest to the point of positive aversion for reading matter and its content. In some cases it was so strong that the act of attempting to read was really painful." She does not imply that this attitude was the primary cause of the reading disability, however; rather she believes that "the reaction of unpleasantness toward the content of books was probably a conditioned reflex, since the content had always been experienced together with the difficult psychological process of reading it".[3]

While recognizing that disability in reading may be due to any one of a number of possible conditions or combination of conditions,[4] there is evidence in some of our case studies that emotional conditionings may be the predominant factor in etiology. This is also true of disabilities in arithmetic. In the following case reports we shall try to bring out the causal relationship between attitude and disability. The first two are cases of disability in arithmetic, the other three in reading.

[1] *A Study of Learning and Retention of Young Children*, by Lois Meek. Contributions to Education, No. 164. New York: Teachers College, 1925.

[2] *The Improvement of Reading*, by A. I. Gates. New York: The Macmillan Company, 1927. p. 23.

[3] *Disability in Reading and Its Relation to Personality*, by E. M. Hincks. Harvard Monographs in Education, Series I, Vol. II, No. 2. Cambridge: Harvard University Press, 1926.

[4] See *Reading Disabilities in Relation to Maladjustment*, already cited.

CASE I

Peter was referred for clinical study and treatment because of poor school work, particularly in arithmetic. He was nine years old and in the high third grade, which he would have to repeat unless his work showed remarkable improvement. It was within two months of the end of the half year when promotions would be determined.

The usual order in clinical study provides that the social history be taken prior to the physical, psychological, and psychiatric examinations. In this case, however, it happened (because of certain practical considerations) that the social worker's first interview with the mother took place while the boy was being given the psychological and educational tests. Because his experiences were unknown at the time of the testing, the report of the psychologist is all the more significant:

"In regard to arithmetic, it is interesting to note that Peter is better at reasoning than at computation. The former is satisfactory for low third, the latter for only high second grade. On the whole, his arithmetic is not so bad, the subject age being 8 years, 5 months, but it is very poor in comparison with his achievement in reading and spelling. *The chief difficulty with arithmetic seems to be the emotional response to it. A distinct blocking is shown in his delayed responses and his reluctance to attempt performances when any test with figures is given.* His errors are erratic, and obviously rise out of a state of mental confusion rather than from intellectual incapacities. He succeeds on difficult examples after failing in easier ones. For instance, after adding 17 plus 2 incorrectly, he adds 16, 53, and 32 rightly; and after giving a wrong answer in subtracting 5 from 16, he subtracts 25 from 96 correctly."

For the rest of the psychological report, it is only necessary to state that the boy's intelligence quotient was 93; that his reading was satisfactory for 9 years, 10 months, and 4.0 grade, and his spelling for 10 years, 10 months, and 4.9 grade.

Peter's mother explained to the social worker that she had always had to worry about him for one reason or an-

other. When he was an infant, it was his health; since then it had been school. Why was she so anxious about the boy? It seemed that her mother had suffered from mental disease and had been in a state hospital for some years; also she had a brother with whom she had given up all contact some time before because of his irresponsible conduct. She had worried about the effect of this heredity on Peter, and had felt that her care and training must protect him from it.

The physical care that she had given the boy showed good results. Although he had been a sickly infant, at the time of his visit to the clinic he was in excellent physical condition. His mother gave a detailed account of the dietary instruction that she had followed during his early years, and that she had evidently carried out very conscientiously.

Her help with his arithmetic had had a different outcome. She began to take this in hand early in his school attendance, but with little success. She tried to "drum it into him", she explained, but he made many mistakes. Even when she threatened, "If you get this wrong again, I'll whip you", he repeated his errors. She whipped him, but this did not seem to persuade him to do better. She was somewhat evasive about the frequency of punishment, but admitted that she had tried it rather often until the principal of the school told her to stop. Since then she has not whipped him "except when he wouldn't say the tables right".

It seems clear that experiences such as Peter had had in association with arithmetical tasks might easily set up a conditioned emotional response to the subject. This is probably just what happened. Undoubtedly, the stimulus "arithmetical task", instead of initiating a chain of intellectual processes leading to the solving of the problem, set up emotional reactions of fear and dislike. These attitudes interfered with the orderly processes of association and memory necessary to do the arithmetical tasks correctly.

With such intense emotional conditioning to overcome, it was obviously impossible to hope for any change before the end of the school term, and Peter was not promoted. Remedial work with the boy was carried on during the three months' summer vacation, the guiding principle being the

necessity of making arithmetic a pleasant rather than an unpleasant experience, and of reconditioning his emotional response to it. To this end, Peter and his tutor nibbled a bit at sweets during the lesson, played games in which arithmetic figured, and occasionally went for an automobile ride, doing the lesson at intervals between discussing the scenery. The tutor noticed that Peter enjoyed the games and could do the arithmetic involved, except when he chanced to think of it as *arithmetic*; if she could keep his interest in the game from flagging so that he did the arithmetic more or less automatically, he got along with it very well.[1]

At the close of the three months' remedial teaching, the arithmetic tests were repeated. The arithmetic computation tests given when he first came to the clinic showed a subject age of 8 years, 2 months, and a 2.8 grade score; the later tests showed a subject age of 9 years, 6 months, and a 3.7 grade score. His accuracy in addition, subtraction, and multiplication had improved remarkably, and he was beginning to understand short division.

Meanwhile, psychiatric treatment had been directed toward work with Peter's mother. As our acquaintance with her progressed, it became very clear that her drive to have him succeed was based on her fear that he, like the members of her family previously described to the social worker, might be mentally abnormal. She was reassured on this point, and was praised for the physical care she had given the boy. The security that she obtained in this way enabled her to accept suggestions for moderating her anxiety about Peter's school accomplishment.

When school opened, an attempt was made to persuade the principal to try Peter in the low third grade. The principal was unwilling to act upon this suggestion, but stated that he would promote the boy if his work during the first

[1] Miss Freda Antinoph, who did the remedial teaching, invented some ingenious methods for unconditioning. She devised games in which pieces of candy were called soldiers, and Peter was to tell how many were left, while he was permitted to eat those that were killed; or another game in which Peter was a cashier in a bank with candy money. Her detailed report of her remedial teaching furnishes interesting material because of the combination of progressive education methods (play motivation) with Watson's suggestions for unconditioning through forming new associations with visceral affects.

few weeks of school confirmed the results of the tests given at clinic. Unfortunately, the second-grade teacher, although not the same one he had had before, was an elderly woman with rigid ideas of discipline. No doubt her stern attitude was sufficient to revive the boy's conditioned emotional responses after the first few days, and his arithmetic was as poor as ever. Hence the hoped-for promotion was not granted.

Peter's mother was by this time sufficiently at ease about his normality to be entirely serene about the grade repetition. But Peter was unable to understand his difficulties. He remarked that he could do arithmetic very well in the summer and he didn't see why he should be having trouble with it now. It is unfortunate that he is too young to grasp the psychological explanation of these puzzling facts.

Despite his bewilderment, Peter does not seem to be unhappy. His mother has ceased entirely to coach him with his home work. Instead of spending the afternoons drilling him in arithmetic, as she used to do, she sends him to the Y.M.C.A. recreational center, where he has a good time with the other boys. Probably his anxiety about repeating the high second grade is a reflection of the attitude his mother formerly had toward grade repetition.

It is interesting to speculate about what might have happened if we could have managed the treatment of this case a little differently. Perhaps it would have been better if Peter could have had a summer free from all thought and mention of arithmetic, since laboratory research has shown that sometimes the conditioned emotional response will weaken or even disppear through disuse. After such a quiescent period, the new pleasant responses could have been set up more permanently, in all likelihood. But this plan could not have been put into effect while Peter's mother still maintained her drive to have him succeed in school, and the remedial teaching with a special tutor at least served as a device to induce her to keep hands off while the psychiatrist gained time to change her attitudes. Next summer, she plans a vacation free from all mention of school work and devoted to recreation.

CASE II

Felix was another boy who had trouble with arithmetic. He was twelve years of age and in the seventh grade. He had transferred from one school to another at the beginning of the sixth grade. In the first school that he attended he had always received very good reports. The second school had somewhat more rigid standards of scholarship, particularly in the upper grades, where the drive for college board requirements made itself felt. From this school Felix received poor reports, especially in arithmetic.

In discussing the matter with the psychologist, his mother said, in part: "It is strange we never thought of him as being stupid before, but he always had such good reports from the other school. His father has tried to help him with his work and has noticed that he does not seem to be able to reason about the arithmetic problems. At first we did not think this was so serious, but now they are suggesting that he be demoted to the sixth grade again. He doesn't seem to have any reasoning ability at all—he just bluffs." She admitted that his father had pointed out his disability to him.

When examined, Felix proved to be far from "stupid", having an intelligence quotient of 122 according to the Stanford-Binet intelligence test. He talked frankly about his difficulty with arithmetic, saying that it was poorly taught at the first school that he attended. "All I ever really understood was the least common denominator." Despite his frankness, he was ill at ease and flushed painfully during the discussion of arithmetic. He remarked that he knew he could not "reason" properly about the problem. "I just look at the figures and try to do something with them."

That this was the method he had adopted was evident in watching him work. His first answers were invariably incorrect because they were guesses. When asked to work the problems aloud, step by step from the beginning, taking time to think them through, he was able to do them correctly.

It was then pointed out to him that he had just shown that he *could* reason correctly and that he could do arithmetic

problems when he took time; that his failures came about because he considered that it was useless to try, and resorted to guessing. After this discussion, the Stanford achievement arithmetic reasoning test was given, and he applied the explanation so well that his achievement was satisfactory for 14 years and 8.0 grade.

The psychologist's interpretation reads as follows: "Apparently, so far as arithmetic is concerned, his attitude toward it has been so conditioned that he has no confidence in his ability to solve problems, feels quite hopeless, and in desperation depends upon guessing. This is what his mother calls 'bluffing', but she thinks it is done deliberately and consciously, whereas it is rather a defense mechanism whereby he tries to release himself from a painful situation which he feels inadequate to meet successfully."

It was considered hopeful that he did not project his difficulties upon the school, but was willing to assume the responsibility for his failures. Because of his frankness in facing his situation, it seemed possible that he could be helped by discussing it further with him. When this was undertaken, he proved to be exceedingly interested. He wished to go over the arithmetic tests in detail. The interpretation of his disability was once more given to him, stressing the point that his discouragement and lack of self-confidence were at the root of his troubles, and emphasizing his good intelligence and the ability to do arithmetic that he had shown on our tests.

Felix was much moved during this interview. He flushed frequently, but kept his voice steady and asked several relevant questions, pressing some topics further than the remarks volunteered by the psychologist. He inquired whether he had sufficient ability to go to college, explaining that he had become discouraged about this since he was getting such poor reports from school, although previously he had planned upon a college education. He was told that with a little help now, in order to overcome his present maladjustment, he should be able to think of high school and college work as within his reach. This led appropriately to the introduction of the subject of remedial teaching, and a plan was broached on the basis of providing him with help until he should be

caught up with his school work, after which he would undoubtedly be able to manage things for himself.

A similar explanation was given to the parents and to the school. Tutoring was provided so that the father's patience need not be tried further in working with the boy. An essential feature of the remedial teaching was building up the boy's confidence in his ability to do arithmetic by keeping a record of his work and showing him the steady improvement that he was making. As his increasing confidence began to carry over into his school work and his marks improved, he was still further reassured as to his capabilities. The demotion that had at one time been considered never took place; on the contrary, he was promoted to the eighth grade at the end of the school year.

CASE III

The case of Richard was partially reported in a previous article,[1] but because the treatment resulted so differently from the optimistic prognosis given at that time, it seems worth while to refer to the initial study very briefly and to give an account of the subsequent remedial work.

Richard, who was nearly twelve years old and repeating the fifth grade, was considered mentally retarded. As readers of the previous article may recall, however, when examined, he had an intelligence quotient of 133 and the real cause of his school failure was a reading disability, his achievement in this subject being more than six years below his mental age and two years below his school grade. (Reading age was 9 years, 2 months, 3.4 grade.) During his first years in school, his father had attempted to help him with his reading, but had been so critical that the lessons usually ended in an outburst of tears from the boy and protestations that he could not do anything his father required. After two years, the father realized that he was making the boy miserable, and discontinued helping him with his work. However, it is probable that by that time a definite attitude of dislike for reading and distrust of his ability to read had been set up in the boy.

[1] See Case IV, pages 785–87 of *Reading Disabilities in Relation to Maladjustment*, already cited.

Psychiatric work was instituted with both parents. With the father the aim was to relieve him of his own feeling of inferiority and sense of failure and to rehabilitate him vocationally. It was hoped that the mother could be given more insight into her reactions toward the father and Richard. It was expected that she would eventually be able to accept the father, and consequently Richard, who was identified with the former in her mind, instead of rejecting them both and turning to her younger son for emotional satisfaction.

From the beginning, it was recognized that only such fundamental changes in the parents would alter their critical feelings toward Richard and permit them to regard him with approval as a normal, lovable youngster. But a long period of time is necessary to help adults to arrive at self-understanding and readjustment. Ten months have not succeeded fully in accomplishing this with Richard's parents. Although some modifications can be seen, it is only the beginning of what we should wish for them.

The persistency of the family tensions has been a very real barrier to remedial teaching for the reading disability. Richard had three months with an expert tutor, but his advance was not so rapid as a boy with his superior intelligence would have made in a more favorable home atmosphere. It sufficed to help him improve his school reports and to win him a promotion, but he is finding sixth-grade work very difficult. Neither the teachers at school nor his mother at home have displayed confidence in his capability, and their distrust, which has been plainly shown, has caused him to retain his attitude of self-depreciation and his dislike of reading. Moreover, on one or two occasions, his mother has been so unwise as to give him an assignment in reading as a punishment for some misdemeanor.[1] What will come of further treatment remains a problem of the future.

CASE IV

Thomas was a nine-year-old boy in the third grade of an excellent private school. His parents requested clinical study on the grounds of backwardness and sensitiveness about read-

[1] Aside from the reading disability, which is our primary concern in this study, it should be noted, in connection with the report of the case presented in the previous article, that his behavior has shown little change for the better.

ing. Interestingly enough, he was not very greatly retarded in this subject, according to psychological tests. His mental age was 9 years, 4 months, intelligence quotient 104 by the Stanford-Binet test, while the Gates primary reading tests showed that his achievement in that subject was satisfactory for nine years and 3.3 grade. His sensitiveness was very evident, however; he was reluctant to undertake the tests and insisted that he was unable to read. He was overanxious, asking repeatedly how much more time he had while working on the reading.

There had been much discussion of his reading at home. Apparently his father had been unusually preococious in acquiring proficiency in reading, and was constantly comparing the boy's achievement with what he had been able to do at the same age. Thomas had for some months been refusing to read in his father's presence. He explained to the psychiatrist that if he stumbled or mispronounced a word, his father would immediately "snap him up". He remarked that he did not mind reading to his mother, because she did not scold him when he made a mistake. He added that he did not seem to make so many errors when reading for her.

This case is particularly interesting in that it shows a reading disability in the process of formation. It was caught in time to prevent the development of a real disability, but had the situation described above been permitted to continue over a period of time, undoubtedly the boy's attitude would have become one that would have inhibited normal progress. Very little remedial teaching was necessary, and none has been done outside the school. The treatment was concentrated on leading the parents to realize that the boy's ability was average for his age and grade, and that they had set up too high standards of achievement. The destructive effect of constant criticism and of placing goals too high for the boy ever to attain them was also explained. Since the parents were well adjusted, they were able to understand this intellectual approach to the problem, and consciously to alter their conduct. Thomas was reassured as to his ability by both the psychologist and the psychiatrist.[1]

[1] Had the father's original criticism grown out of personal maladjustments on his part, this simple method of handling the treatment undoubtedly would have been too superficial, and would have failed to produce the desired effect.

A year after the original clinic study, Thomas was again given reading tests. While he still read slowly, his comprehension was satisfactory for fourth grade, which was his school placement at that time. He was much less anxious, the only indication of anxiety being his eagerness to know how he had done on the tests. Both father and mother were satisfied with his progress.[1]

CASE V

This case has recently come to our clinic, so that only the diagnostic study can be reported. It is that of an eleven-year-old girl with an intelligence quotient of 110. Although the major problem is in the behavior field, a minor one is her poor reading.

She hates to read; she will not do assignments for supplementary reading for any of her school subjects, and gets poor marks in those that she must learn from books. Thus her only good marks are for arithmetic and geography (which is taught largely by map-making and project methods). She is now halfway through the sixth grade of school. On silent reading tests, her comprehension is adequate for the beginning of the sixth grade, but rate is only at the 4.5 grade level. The fairly good comprehension is due to her ability to guess at meaning from context in spite of failure to recognize some of the words. In oral reading she makes many errors. Her score on a word-pronunciation test is only 10.8 years and 5.0 grade, while tests demanding sharp visual discrimination for distinguishing one word from another give her only 7.1 years and 1.6 grade proficiency.

Her attitude toward reading (like her misconduct) is a part of her negativistic reaction to her mother and to anything that the mother suggests. She feels much more affection for her father and links herself with him in every possible way. The intensity of her identification with her father is equaled by the force with which she rejects her mother. She

[1] It should be understood that a physical examination is a part of the routine clinical study of cases, and that whenever there is a reading disability, the vision examination is an especially thorough one. For a case of reading disability arising from visual defect see Case III reported on pages 783–85 of the article *Reading Disabilities in Relation to Maladjustment*, to which we have previously referred.

wants to do everything that her father suggests, but rebels against anything advised by the mother. She says, "Seems to me every time I ever told my mother I had nothing to do and wanted her to do something with me, she just told me to go read a book." She insists that she met with this reply before she had begun school.

The mother's unwise stress on reading probably arose from a feeling of inferiority on her own part. The father is a professional man, who has had to read a great deal. The mother is not so well educated and has felt this difference keenly. Since her marriage, the mother has tried to become a reader and has also been anxious to have her daughter interested in books. Unfortunately, she wanted to enforce the habit at an early age, before the child had mastered the mechanics of reading or could obtain any intrinsic pleasure from it. Thus she succeeded only in rousing a resistance in the girl, which has increased in direct proportion to the mother's nagging about the matter.

Perhaps, but for the girl's antagonism to her mother on still other grounds (which are too complex to be given in detail), she would not have developed the dislike of reading, or at least would not hate it so intensely. It is quite likely that while her attitude prevented her from acquiring proficiency in the reading process, this very lack of proficiency now operates to accentuate her attitude. That is, besides the conditioned response set up in association with the mother, the difficulty that she experiences in reading makes it in itself an unpleasant experience. Just where one can make a break in this circular type of response is a nice problem in remedial teaching.[1]

CONCLUSIONS

1. We have presented five cases that show disabilities for reading or arithmetic in which the cause seems to be primarily

[1] While this case is perhaps too mild to be considered a serious reading disability (see definition given in *Reading Disabilities in Relation to Maladjustment*, page 774), the emotional attitude is so marked as to justify its inclusion in this report. At least it is likely that this girl's proficiency in reading is sufficiently poor to interfere with her making the normal educational progress in keeping with her intelligence level.

the child's emotional attitude toward the particular subject. In each case this attitude was the result of parental influence.

2. An important treatment problem seems to have to do with the parents. When their handling of the child can be changed, it is usually possible to change the child's attitude and to overcome the disability by special teaching methods. If the parent-child relationships have grown out of emotional maladjustments on the part of the parents, the treatment process is a long and difficult one, and remedial teaching is apt to prove less effective.

3. The school may also facilitate or retard treatment by providing situations that will give the pupil an opportunity to feel successful, or by keeping him in situations that increase his sense of failure.

4. Undoubtedly, disabilities in other subjects than reading or arithmetic may sometimes arise from emotional conditionings. It happens that our clinic cases are limited to these two subjects. This is probably due to the fact that reading and arithmetic are still to be regarded as the fundamental skills that must be acquired before the pupil can go on to more advanced work in other subjects which depend upon foundation work in these two.

5. It should be repeated that attitude is not the sole cause of educational disabilities. There are many others. It is one that has been too little discussed in the literature, however, and is especially important from the preventive point of view.

6. It seems essential for parents and teachers to understand that criticism and punishment bring into the learning situation an opportunity for setting up conditioned responses that are liable to produce educational disabilities.

DISCHARGES AGAINST ADVICE FROM A PSYCHIATRIC HOSPITAL WITH ONLY VOLUNTARY ADMISSIONS

A STUDY IN SOCIAL PSYCHIATRY *

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IN recent years psychiatrists have ventured more and more into the field of the social application of psychopathology. The increase in our ability to detect mental disorders in their early stages, as well as the more extensive and intensive study of the milder forms of mental disturbances and of the psychopathic constitutions, have brought psychiatry into ever closer relationship with the social sciences. Not infrequently psychiatry—or it is perhaps more just to say psychiatrists—have attempted tasks beyond their capacity in this wider social aspect of scientific psychopathology. Extreme psychiatric proposals in the various branches of education and one-sided solutions of the theoretical and practical problems of criminology and legal practice may be quoted as examples. The more enthusiastic advocates of what often appears to be a sort of diluted applied psychiatry, further and further removed from the base of clinical psychiatry as a branch of modern medicine, might well remember that a very large part of the community still views this encroachment with grave suspicion.

Has psychiatry studied adequately those social problems which are most closely related to the care and treatment of mental patients? This question is asked by not a few observers of social phenomena, as, for example, recently by Londres in his attack on psychiatric procedure, especially the circumstances connected with the confinement and discharge of mental patients.

* Read in abstract at the meeting in celebration of the fifteenth anniversary of the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, April 30, 1928.

It is proposed in the present study to investigate a situation frequently encountered by the practicing psychiatrist—namely, discharge against medical advice. Here evidently in most cases psychiatry does not deal with the individual patient alone, but faces definite social responsibilities. The question of premature discharge is a very old one, but the situation has changed a great deal with the development of the procedure with regard to mentally afflicted persons. Originally mental patients were detained in prisons and there was no difference between the "insane" and criminals, as the old historical records show. They were later segregated from criminals in special places which were nothing more than prisons, although used only for the "insane" (*e.g.*, the old *Narrenhäuslein*, as they were called, in Germany). This development seems to have begun in several countries in the fifteenth century. From this original germ, so to speak, the later places of detention and treatment — asylums, institutions, state hospitals, psychiatric clinics—have evolved. The *casa di custodia* of Italian criminologists, a "hybrid institution" for both penal detention and psychiatric-therapeutic procedure, represents an interesting stage in this evolution. In the famous Bastille in Paris there were confined, as Sérieux and Libert [1] have found from a study of the old archives of the prison, a "notable proportion" of mentally ill individuals, against whom there were no criminal charges. They were sent there as a matter of social policy, far in advance of the times. In popular opinion there is still a certain connotation of the "prison" connected with the concept of mental hospitals, partly unjustly, but not entirely so. The fact that a legal procedure is frequently necessary in order to have a patient admitted to a mental hospital of course plays a part in the readiness with which the popular mind makes the archaic analogy between the psychiatric hospital and the prison.

Systematic studies of discharges against advice from hospitals with only voluntary admissions have not been made.

[1] *Prison d'Etat et asiles de sureté. Les anormaux constitutionnels à la Bastille; interprétateurs, revendicateurs, fabulateurs*, by Paul Sérieux et Lucien Libert. *L'Encephale*, Vol. 6, p. 192, 1911.

Discharge from such hospitals is of course very similar to discharge from other mental hospitals,[1] but it presents new aspects of the problem and shows in a more precise form the general problem of the relation of the psychiatric hospital to the community. If, year after year, patients are given the benefit of psychiatric treatment in a hospital especially adapted to their needs, and if some of them after admission leave the hospital before their discharge seems medically advisable, a number of questions present themselves for investigation. The physician is apt to describe this state of affairs *a priori* as due simply to ignorance and prejudice. For a more socially oriented psychopathology, however, a number of unsolved problems arise. How many and what type of psychiatric patients will leave the hospital? Does the initiative for the change come from the patient or from his relatives and friends? What are the reasons for the change? What aspects of hospital life enter into the decision of the patient's leaving, and can they perhaps be modified? How great is the danger to the community from these discharges? How do they contribute to the question of the medical indication for hospital treatment for the various types of mental patients? What is the distribution, both actual and psychological, of responsibility between the individual, the family, and the community?

The material of the present study includes all the patients discharged against medical advice from the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, during a period of eight years. It is a matter of routine in the clinic to have persons who ask for what is considered premature or undesirable discharges sign a statement which explicitly states that they assume all responsibility. In this procedure the intention of the physician often is to make relatives or friends

[1] A valuable study of discharges against medical advice has recently come from St. Elizabeths Hospital, Washington, D. C. (see *Careers of Patients Discharged Against Medical Advice From St. Elizabeths Hospital 1920–1925*, by Elmer Klein, M.D., and Roger S. Cohen, M.D. MENTAL HYGIENE, Vol. 11, pp. 357–68, April, 1927). The cases of this study were formally committed either by law or by executive order, and the discharge against advice occurred mainly in a setting of legal reversal of commitment. It is noteworthy that even in this group of committed cases 25 per cent of the patients concerning whom information was gained were able to remain outside of mental hospitals.

more thoughtful. During the eight-year period included in this study—from January 1, 1918, to the last of January, 1926—193 patients were discharged against medical advice. The number of patients treated during the same time and discharged according to medical routine was 2,758. This means that of the patients discharged during the eight-year period, 6.54 per cent were discharged against medical advice. It would have been difficult to estimate this percentage without exact calculation. It is significant on several scores. The evaluation of this percentage as either high or low depends on the point of view from which it is regarded. One must take into account the fact that the clinic admits all types of patients, from those with slight disease manifestations to those with very severe ones. The general public, including official social and legal authorities, as well as average medical opinion, would assume that a very large number of mental patients have to be kept against their will. From this point of view the number of those discharged against advice seems low. In view of the widespread and persistent popular ignorance concerning mental patients, it might be added that the belief that the more severely disturbed patients are so sick that they do not know what they do or where they are is erroneous. On the other hand, one must remember that the Phipps Psychiatric Clinic can choose its admissions carefully and calculate the eventualities of the patient's and the family's attitude. From this aspect the number discharged against advice seems rather large.

Of these 193 patients 99 were men and 94 were women. The average age of the men was thirty-seven (ranging from nine to seventy-one); the average age of the women was thirty-four (ranging from thirteen to sixty-two). The average age of the whole group was thirty-six. These averages show no significant difference from those of the general run of patients. The same statement holds true for occupations.

The average duration of the stay in the clinic of these patients was 54 days. The shortest stay was one day; the longest stay, 295 days. These figures present nothing unusual

as compared with the average duration of stay of other patients.

The distribution of psychiatric diagnoses among the 193 cases was as follows:

Depression	73
Manic excitement	4
Schizophrenic reaction type	38
Psychoneurosis	19
Organic reaction type (other than general paresis)	11
General paresis	17
Affective reaction with schizophrenic features	7
Constitutional psychopathic personality	6
Delirium	6
Drug addiction	2
Chronic alcoholism	2
Paranoid psychosis	2
Chorea	2
Epilepsy	3
Toxic goiter	1
Total	193

The predominance of depressions is interesting, but is in large part explained by the greater number of depressions among the cases admitted. This is due to the tendency on the part of the clinic to prefer therapeutically hopeful cases. This selection, however, does not entirely explain why there are so many depressions. It is evidently not easy for the social environment of a patient to recognize the milder manifestations of depression as morbid and belonging to the sphere of psychopathology. When the number of depressions (73) is contrasted with the number of manic excitements (4) this is particularly clear. In elated conditions the environment takes a very serious view of the patient's condition, although prognostically these conditions are not less benign than depressions.

The relatively large number (17) of general-paresis cases is also noteworthy. In this condition, on account of its characteristic symptomatology and course, the patient frequently has very little insight and it often is a very long time before the environment realizes that there is a profound mental disturbance present.

The small number of cases of drug addiction (2) and of

chronic alcoholism (2) is due to the fact that these patients are admitted to the clinic only in exceptional cases.

The small number of paranoid psychoses (2) discharged against advice (compared with the much larger number of paranoid psychoses treated during the same period) shows that these conditions can be treated in psychiatric hospitals without commitment much more extensively than is commonly assumed.

The difficulty of disentangling the psychological causes of social events is apparent when it comes to assigning the initiative for the disregard of medical advice for further treatment. It would seem at first glance that it should be possible to distinguish neatly between the group in which this initiative came from the patient and the group in which it came from his family. A closer study of the data, however, makes it necessary to formulate a more relative classification.

There is one group of cases in which *the patient demands to leave.* It may be pointed out here that since the clinic admits only voluntary patients, the patient has to be discharged in the event of his definitely wishing to leave. In such cases the family is informed and advised to take the patient to another hospital. Cases in which the family complied with this request and the patient was transferred immediately to another psychiatric institution are not included in the present study. The group of patients in which the initiative for the discharge against advice came from the patient includes those cases in which the patient demanded release, disregarding the advice either to stay or to go to another psychiatric institution, and was taken home by relatives.

A second group of discharges against advice comprises those cases in which *the family wishes the patient to leave.* In this group are included only those cases in which it is entirely clear that the initiative came directly from the relative and not from the patient. In this second group a smaller subgroup was singled out in which it could be clearly shown that the relatives took the patient home, not only without his wanting to go, but expressly against his wishes.

A third group of cases was found more difficult to define,

the *initiative* for leaving the clinic being *divided between the patient and his relatives*, the patient persuading his undecided family to take him away.

In a fourth group the discharges against advice occurred in the following setting: The *clinic wished the patient to leave*, for various reasons to be discussed later, and the family was *advised* to *transfer* the patient to another psychiatric institution. Instead, they disregarded the advice and took the patient home.

In a small fifth group the patient was discharged on trial for an *experimental visit* home, to return to the clinic after a certain time, but instead of returning he *remained away*.

The distribution of cases among these five groups is as follows:

	Cases
Group 1. Initiative due to patient	26
Group 2. Initiative due to family of patient	99*
Group 3. Family is persuaded by patient to take him out	47
Group 4. Clinic advises transfer, but patient is taken home	17
Group 5. Trial discharges	4

* In 10 of these cases the patient was removed expressly against his own wishes.

These figures show definitely that the largest number of patients are taken out by their families. In only 26 cases out of 193 was the patient's demand to leave the decisive factor.

The third group differs from the first in that although the patient has expressed a wish to leave, he could have been induced to remain, had not an active part been taken by the family. In these cases the members of the family either identified themselves with the wishes and reasons of the patient or they magnified, exaggerated, or distorted them. Since in these cases it is the family that takes the active part and comes into disagreement with the physician on the question of the discharge of the patient, one may in a sense say that in 146 cases out of a total of 193, the family attitude presented the physician's problem, as against 26 cases in which the attitude of the patient led to the change (leaving out groups 4 and 5 where hospital arrangements entered into the situation).

The next step of the inquiry was to determine the motives

behind the discharges against advice. One-half (13) of the patients in the first group, in which the patient demanded his discharge, gave no reason for their wish to leave. In the other half of this group the reasons given were the following: resentment on account of confinement; dissatisfaction with the ward; the patient's opinion that treatment in the clinic was unnecessary; lack of confidence; discontent with the hospital; discomfort from drug-withdrawal cure; and, in one case of exophthalmic goiter, fear of operation. The diagnoses of the patients in this group were as follows: drug addiction; brain tumor; spasmodic tics; agitated depression (2 cases); agitated depression with paranoid features; hypochondriacal depression; anxiety neurosis with depression; schizophrenic reaction type with depressive onset; hypomanic reaction type in a chronic alcoholic; exophthalmic goiter; cerebro-spinal syphilis; chronic alcoholism; and tabes. There is little of interest in the details of discharge of these patients.

In the second group, which includes patients taken from the hospital at the wish of the family, the actuating motives are more interesting and significant, since they throw light on the social relationship between the psychiatric hospital and the public. Again, as in the first group, no reason was given in approximately one-half of the cases (52 out of 99). In the other half of the cases the family, in asking for the patient's discharge, gave a motley array of reasons, some of which had little, if anything, to do with the clinic or the patient's sickness and treatment except in so far as it caused a separation of the patient from his family. For example, a husband wanted his wife to be at home, or a wife her husband; a mother wanted her children at home; the relatives had promised the patient to remove him after a certain time; a wife wanted her husband at home because she was jealous of his special nurse; the responsible member of the family was himself mentally disturbed (2 cases).

Other reasons were based on the attitude of the relatives toward the patient's illness. For example, they had no insight into the patient's condition; they made their own diagnosis or wished to map out their own treatment; they misunderstood the patient's behavior (depression, delirium);

they found his improvement too slow; they thought the best thing for the patient was a "change"; they wanted to try a cure in the country; they wanted treatment at home; they considered the case "incurable", "hopeless", "might as well die home". The diagnoses of the cases in the last mentioned group were organic brain disease; depression with schizophrenic features; post-traumatic aphasia; reactive depression.

Further reasons were concerned with the attitude of the relatives toward the clinic itself: they objected to a psychopathic hospital; they believed that the hospital "made the patient ill" or kept him ill; they did not coöperate with the clinic; they were dissatisfied with the visiting routine; they were dissatisfied with the special ward where the patient was; they were dissatisfied with the treatment; they objected to the discharge of an inefficient special nurse. In 2 cases (out of 193) the question of expenses was a main issue. It should, however, be pointed out that the Phipps Clinic is in the fortunate position of being able in certain cases to adjust expenses to the financial status of the family.

In the third group of cases, classified as those in which the family is persuaded by the patient to take him home, no reasons were determined in 16 discharges out of a total of 47. For the remaining 31, the following reasons were given: desire to be home, "homesickness" (14 cases); discomfort due to drug-withdrawal cure; patient's lack of insight into his condition; general lack of coöperation in regard to his treatment on the part of the patient; patient's delusional ideas; "cruelty in hospital" (1 case); dissatisfaction with ward; discontentment on account of hospital confinement; patient's belief that the hospital "kept him ill" (3 cases).

There are, then, two final groups (21 cases) in which the clinic either advised the relatives to take the patient to another psychiatric institution and they refused and took him home instead (17 cases), or in which the clinic advised and arranged a trial discharge or experimental visit of fixed duration and the patient remained away (4 cases).

It is not without interest to determine which member of the family took the initiative and responsibility in removing

the patient against medical advice. In only 25 cases did the patient leave by himself.[1] Seventy-four patients were taken out by husband or wife. Parents took out their children in 34 cases; in only 10 cases did children take out their parents. Patients were removed from the clinic by brothers or sisters in 17 cases. In 33 cases several members of the family took joint action. Too definite conclusions should not be drawn from this distribution. It is of importance, however, that in only 25 cases (12.9 per cent) did the physicians have to deal with the patient alone. In all the other cases the family was the socially decisive factor. The ratio of 34 parents who took out their children to 10 children who removed their parents may point to an overconcern of parental affection and perhaps to a certain lack of concern of the children for their parents.

Of special importance to the physician should be those cases in which the family is divided against itself. This situation is sometimes not brought out or sufficiently considered during the patient's stay, but becomes apparent only when he has to be discharged against medical advice. In this material, disagreement in the form of husband vs. wife's relatives and wife vs. husband's relatives is the most frequent. Very typical of this is the case of a young woman twenty-seven years old who was suffering from a recurrent depression with self-reproaches and suicidal ideas. When the husband came to remove his wife from the clinic and to take her home against medical advice, he answered my questioning as follows: "It is against my better judgment. Her family wants it. They insist she will not get well here because she is worried at having to stay here." Speaking about the seriousness of the suicidal risk, he said: "They just don't believe it. They are not capable of judging. I have put up with an awful lot these eight months from her family—more than you can imagine, Doctor." In such cases the physician finds himself face to face with two factions of the family and has a definitely social task that is not easy, but that nevertheless should not be shunned.

[1] A distinction has been made between the group in which the initiative for leaving was due to the patient (26 cases) and the group of patients who left on their own responsibility and by themselves (25 cases).

The opinion of the clinic as to the progress of the patient during his stay in the clinic is shown by the following figures:

	Cases
Improved	83
Slightly improved	5
Unimproved	104
Not treated	1

This shows a marked predominance of the unimproved cases. It would be difficult to compare these figures with the corresponding figures for routine discharges. The fact that the majority of the patients discharged against medical advice were unimproved at the time of discharge speaks for itself.

The further career of all these patients was investigated through an interview of the patient or his relatives by a physician wherever possible; otherwise by letter or through "follow-up work" by a social worker.[1] It is a fact well known, though insufficiently taken into account in statistical psychiatric investigations, that it is exceedingly difficult to determine in any large number of cases to what extent an adjustment at home is really due to improvement or recovery of the patient and to what extent to a stretching of all possible resources and makeshifts of the immediate environment to which the patient returns. In the individual cases this elasticity of the home and work environment is of the greatest importance for the determination of the need of hospitalization and its duration. The heading "satisfactory adjustment outside of the hospital" is, therefore, to be taken as an unavoidably relative statement of the facts.

The subsequent careers of the 193 patients discharged from the clinic against medical advice may be tabulated as follows:

	Cases
1. No information	21
2. Returned to mental hospital	60
3. Admitted to jail	1
4. Unimproved at home	15
5. Suicides	8
6. Suicidal attempts (with subsequent adjustment, 3 cases; with subsequent admission to mental hospital, 5 cases)	8

[1] I am greatly indebted to Miss K. K. Barton, head of the psychiatric social-service department of the Johns Hopkins Hospital, for her aid in this follow-up work.

	Cases
7. Sudden death, possible suicide	1
8. Homicidal attempts (with subsequent admission to mental hospital)	8
9. Died	7
10. Satisfactory adjustment outside hospital	64

If one subtracts from the total number the cases in which no catamnestic information could be obtained and the patients who have died, it appears that out of 165 cases, 64 made a satisfactory adjustment outside the hospital. This seems a comparatively large number. A slightly larger number of patients (73) had to be readmitted to psychiatric hospitals.

Homicidal attempts occurred eight times, if one includes two serious homicidal threats. The diagnoses of the patients who made homicidal attempts were: recurrent depression; agitated recurrent depression with a possible early organic basis; paranoid reaction type; anxiety neurosis with paranoid trend (jealousy delusions); constitutional psychopathic personality; alcoholic hallucinosis with schizophrenic features; schizophrenic reaction type with some hysterical features.

The "homicidal attempts" include the following: threats to shoot wife; threats to shoot children; attempt to choke wife; pursuit of family with carving knife (followed by arrest by police); pursuit of wife with large butcher knife; firing of three shots into wife's neck, two days after discharge; attack on father with a carving knife, with resultant slash from his forehead to his throat.

Considering the large proportion of depressions in the whole group under consideration, the number of suicides (8) is relatively small. The suicide rate of patients discharged according to medical routine in the same period, which is of course a very much larger number of patients, is higher. It would seem from the figures that the danger of suicides and serious injury to others is somewhat smaller than one would assume. The real difficulty is a selective one—the determination of the suicidal risk in the individual case. Just as the psychopathology of suicide is not as yet clear, so our prognostic aids with regard to suicide are still very incomplete. It would be unwarranted clinical pessimism to claim that the determination of the degree of danger of future suicide will always be a matter of the individual case beyond

any more far-reaching generalizations. There must be here, as in other psychopathological phenomena, typical chains of events which a deeper analysis will reveal. It is possible that among the 8 patients who died there were cases in which death might have been preventable had they remained in the hospital.

It has not been the aim of this study to exploit all the statistical possibilities of the material and to force the data into a frame of diagnostic labels, average course of disease, and so forth. Rather did it seem worth while to study a situation that falls within the scope of social pathology for itself, with a view to deriving practical conclusions in regard to possible elaborations and modifications of psychiatric procedure. Out of an average number of 366 admissions per year, 24 cases (6.55 per cent) are discharged against medical advice. Depressive conditions and organic reaction types, especially general paresis, deserve to be mentioned as entering to a considerable extent into this number. Manic excitements are conspicuous by their rarity, as are also—contrary to expectation—essentially paranoid psychoses. As regards sex, social status, profession, and length of stay, the cases studied do not show significant variations from the average of admitted patients.

Subtracting the cases in which considerations of the clinic entered into the discharge, it becomes evident that in only 26 cases, or 15.1 per cent, was the discharge due to the patient's wish alone. In the majority of cases (99, or 57.5 per cent), the family took the initiative, while in 47 cases (21.5 per cent) there was a combination of factors, with the family, however, as the decisive agent with whom the physician had to reckon. Some of the reasons given by the patients seem to refer to causes of discontent unavoidable in any large number of hospital admissions. The reasons given by the family have partly to do with the general social consequences of mental diseases. Since they are usually of long duration, the separation of members of the family is a motive for interrupting the treatment. In many cases some member of the family demands the discharge of the patient for the selfish motive, often disguised as unselfish

interest, of having the patient at home. This motivation is very common and familiar. It is mentioned by Rieger among the reasons for discharge of psychiatric patients in Würzburg at the beginning of the seventeenth century.[1] In a large number of cases there is a misunderstanding of the workings of the clinic. Often the decision of relatives to try something else—either a definite procedure, such as "gland treatment", or just a "change"—becomes understandable when one considers that in many cases of mental disease there may be prolonged periods in which treatment has to consist of protection of the patient rather than any active therapy.

Many of the reasons given by the family are accounted for by the general deep-rooted prejudices of the average public in regard to mental diseases. From these general prejudices it is well to distinguish the more specific misapprehensions, doubts, and false inferences caused by the direct contact of the family with the workings of the psychopathic hospital. The current false beliefs concerning mental disease call for a general education of the public; this is an old demand. It is satisfied to some extent, though not completely, by the efforts of the present mental-hygiene movement. The more specific difficulties arising from the direct contact of the family with the psychopathic hospital, however, are not covered by a program of general education.[2] The material of this study would seem to show that there are definite difficulties from which can be derived certain hints as to methods of obviating them.

[1] He gives as an example the record of a patient in the year 1609: "*Junevis 25 annorum, prorsus furiosus . . . a patre domum reducitur eo, quod mater filii absentiam ferre non possit.*" (A young man of 25 in a state of severe madness . . . was taken home by his father, because the mother could not bear the absence of her son.) *Die Psychiatrie in Würzburg von 1583–1893*, by Konrad Rieger, 1899. p. 140.

[2] An interesting and successful arrangement has been inaugurated by Dr. Ebaugh at the Colorado Psychopathic Hospital. The relatives of each patient are invited to attend a series of lectures given by different members of the staff in which the theoretical and practical aspects of mental disease are developed. (See *The Rôle of Conferences With Relatives in the Educational Program of a State Psychopathic Hospital*, by Franklin G. Ebaugh, M.D. MENTAL HYGIENE, Vol. 9, pp. 753–59, October, 1925.) A personal communication from Dr. Ebaugh indicates that discharges against medical advice have occurred less frequently at that hospital since the institution of this procedure.

It appears necessary to emphasize what is shown clearly by the data studied here, that in its social aspect mental disease is not only a problem between the individual and the community in general. In our present-day social and legal organization, so far as the practical social problems of mental disease are concerned, the family as a decisive entity is interpolated between the individual and the community. It is not my intention here to discuss in more detail the legal and moral background of this responsibility of the family. From the administrative point of view, the family's importance is clear enough. A number of patients considered in this study could have been committed and should have been committed; but this was made impossible by the refusal of the family. It is sufficient to state that the social aspect of psychopathology is not, as is too often assumed, exhausted by a consideration of the more or less abstract or absolute needs and safeguards of the community. Every reason given by the family for interrupting a course of treatment deserves careful investigation. This cannot be done abstractly and in general, but should be taken up in each individual case. The circumstances of discharge against advice is only an occasion for the showing-up of a misunderstanding or a disharmony that must have existed long before. This issue is one in which Dr. Adolf Meyer's suggestion of a special formulation of every psychiatric case for the patient, for the physician, *and* for the relatives assumes particular importance. It would seem necessary for the physician to express his findings of a specific mental disease in a way that the family can understand. He will have to explain in simple terms the varieties of treatment and more especially the indications for hospital treatment. The latter point, particularly, presents great difficulties because psychiatric literature seems to have shunned the task of attempting a more precise formulation of the indications for hospital treatment. The more the modern development of psychiatric hospitals with voluntary admission wards gains in extent, the less will it be possible for the physician to rely on legal authority.

The success of coöperation with the family will depend on the clearness and honesty with which the individual case

can be presented to them. That a simple diagnostic label or a formal "mental age" is not sufficient to supply this need is evident. Nor is it sufficient to give the relatives a short-story-like résumé of the more dramatic features of the development of the patient's abnormal behavior. Nor are statements as to the patient's actual behavior sufficient, however well formulated. Without discussing whether or not this is unavoidable, it is a fact that psychiatric terminology, even where it is not Greek or Latin, has developed into a kind of jargon in which words have assumed meanings that they do not have in general usage. To take an example from Londres,[1] who is a reporter and a very good one, reflecting well the attitude of the public, a patient has been in a psychiatric hospital for several years, and as in the case of a considerable number of patients in this study, there is a division within the family. The cousins visit the patient and, finding him "so clear", suspect the right of the wife to keep him in the hospital. They ask an explanation from the physician and receive the following statement: "Mr. X. is physically in very good condition. From the mental point of view, he is calm and docile, but he is unconcerned, indifferent, unoccupied, little conscious of his real interest and without care for his future. His place is still in the asylum, for he could not adapt himself any more to social life." Psychiatrically, this is a clear enough statement of a typical condition. Londres' comment is bitter and partly unjust, but it reflects so well the attitude of relatives, as manifested in the cases of this study, that it may be permissible to quote it here: " 'He's unconcerned!' Why then did he cry for his cousins who finally took him out?

" 'He's unoccupied!' He could perhaps, in recompense for the good care with which he is surrounded, construct a monument in honor of the physicians of the asylum?

" 'He's little conscious of his real interest!' Do you see this person who has been confined for six years and who permits himself to be without concern for the future?

" 'His place is in the asylum because he could not adapt himself any more to social life!' Surely this chief physician

[1] *Chez les fous*, by Albert Londres. Paris, 1925.

does not know what he writes. With these conditions I could have confined twenty of my best friends in one morning—and also the said chief physician."

No one with practical experience of psychiatric procedure will fail to realize that this chief physician's statement is a typical one and not even a bad one; but equally typical is the reaction of the public, in this instance the reporter. The statement of the chief physician steers clear of diagnostic labels and formal prognoses. It is based on facts and accurate data of observation. But how abstractly it is expressed! How vague is the general phrase, "adaptation to social life"! It describes a phantom in an equally impersonal world, the "asylum".

A great deal of the uncertainty of families in their contacts with mental hospitals is explained also by the differences in the expressed opinions of different hospitals to which the patient is successively admitted. Cases 4 and 5 of the present study (see page 582) are examples of how great these discrepancies of formal clinical diagnosis can become. Bowman[1] has recently drawn attention to the "enormous duplication of effort by psychiatric clinics", when patients are brought from one hospital to another after having been thoroughly studied. "Only after a complete social-service investigation is it found out that the patient has been to another clinic."[2]

The divisions within the family brought out in a number of cases in this material deserve to be singled out as a phenomenon that has to be taken into account practically and during the patient's stay in the clinic.

From the further fate of the patients discharged against advice the conclusion can be drawn that on the whole the danger of discharge against advice is apt to be overestimated. As a result of this study it seems justifiable to make the statement that when the relations of the physician with the family come to be regarded as forming an essential part of practical psychopathology, extension of the organization of

[1] *Medical and Social Study of 100 Cases Referred by the Courts to the Boston Psychopathic Hospital*, by Karl M. Bowman, M.D. MENTAL HYGIENE, Vol. 12, pp. 55–71, January, 1928.

psychiatric hospitals with wards for only voluntary admissions is practicable and desirable.

The more clinical aspects of the catamnestic data do not fall within the scope of this study. Investigations of the careers of these patients throw some side lights on certain social aspects of mental diseases. The insignificant rôle at present played by family physicians in the case of mental patients is apparent from this material. (For example, see Case 3, page 582.) There is a great tendency on the part of the physician to give up the case entirely when a serious mental illness develops. Some of the more out-of-the-way treatments taken by patients after discharge are interesting. The cases in which a spell cast on the patient was regarded as the cause of the disease and in which aid was sought by exorcistic means deserve mention. (Examples: Cases 21, 29, and 30, pages 585, 587.) The danger of maltreatment of patients by their families, when home treatment is substituted for hospital treatment in cases in which the latter is definitely indicated, needs to be emphasized. (Example: Case 26, page 586.) The cases where the home environment was apparently instrumental in bringing about an improvement may be pointed out. (Example: Case 7, page 583.) A fuller discussion of these cases would lead more deeply into the psychopathological and clinical aspects of the material than is intended here.

In conclusion, another practical application of the deductions from this study may be alluded to, although it lies somewhat outside the field of clinical psychiatry. Criminologists and psychiatrists have in recent years advocated the introduction or rather the extension of the legal practice of "indeterminate sentence". It has been claimed that the decision for the duration of the legal sentence should be turned over to psychiatric opinion. It would seem that before psychiatry can pronounce upon such questions of social prognosis in any more than a purely empirical fashion, the social aspects of the narrower field of psychopathology will deserve further careful scientific study, in the direction indicated in this paper.

The following illustrative cases are cited as examples in brief summaries, only the essential facts relative to this study being given:

Case 1.—Housewife; aged thirty-nine; married. Husband a clerk. Psychoneurosis. Improved. She was taken out by her *husband* who was *"more difficult to handle than the patient"*. He begged to be allowed to see the patient more frequently than regular visiting days, *complaining of "lonesomeness"*, the difficulty of "bearing the first separation since marriage, inability to sleep or attend to business", and so forth. During one of his too frequent visits, he found the patient slightly discouraged and in a mood to enlarge on her complaints. He became "very much worried", "could not sleep all the following night", and without consulting the patient or the physicians, made arrangements to take the patient home. A report five years later said that the patient had improved since leaving.

Case 2.—Housewife; aged twenty-five; married. Husband a butcher. Agitated depression. Unimproved. Papers were made out to commit the patient to a state hospital, and her husband intended to take the patient there. On the day of the discharge, another relative came to the hospital with the husband and persuaded him to take the patient home instead of to the state hospital. The seriousness of this was explained to them. *The day after leaving the clinic the patient took a large quantity of iodine and died* shortly after.

Case 3.—Housewife; aged forty-one; married. Husband a "canner". Recurrent depression. Unimproved. The patient was taken out because her sisters became angry because they could not all visit her on visiting days. The sisters' physician (consulted by the family) and the sisters felt that the clinic had a personal interest in keeping the patient, that its attitude was due to jealousy and the fact that it was peeved. *Five years later the patient was reported as living with her sisters—never recovered—spending most of her time in bed, with diminished affect and reduction of all activities.*

Case 4.—Housewife; aged forty-seven; married. Husband a carpenter. *Hypochondriacal depression.* Improved. The patient became very persistent in her demands to leave, and her husband took her home against advice. She was later admitted to private sanitariums and hospitals with the following diagnoses: *"nervousness"*, *"involutional melancholia"*, *"neurasthenia"*. The patient is still in a state hospital; diagnosis: *agitated depression.*

Case 5.—Schoolboy; aged fourteen. Father an upholsterer. Schizophrenic reaction type. Unimproved. The patient was discharged to his mother for admission to a state hospital, but she took him home instead. A month later he was taken to a state hospital where he spent a year. *Diagnosis: dementia praecox.* Two years later he was admitted to another state hospital, where he spent about two months. *Diagnosis: manic-depressive insanity, depressed phase.* One day, after leaving this hospital, the patient was again admitted to the first state hospital, where he was diagnosed as a *constitutional psychopathic inferior without psychosis.* He died in this hospital of tuberculosis of the lungs five months after his second admission. (This case and the preceding one illustrate the pitfalls of formal diagnoses.)

Case 6.—Housewife; aged thirty-eight; married. Husband a mechanic. Recurrent depression. Unimproved. *The patient was removed from the clinic because her husband objected to having her on the disturbed ward, although the patient herself made no complaints.* A report eight years later stated that she was at home for two weeks after leaving the clinic, and then spent several months at a private sanitarium. She left there to return home, where she remained unchanged for four years. Since then she has been perfectly well. The patient attributes her illness to grief and her recovery to prayer. She thinks she might have been well at an earlier date if she had remained in the clinic longer.

Case 7.—Housewife; aged thirty-five; married. Auditory hallucinosis (schizophrenic—possibly toxic basis?). Improved. The patient was taken home by her husband and sister because she said that she would be more satisfied at home. A report seven years later stated that *the hallucinosis ended abruptly on departure from the clinic. The patient was precipitated into a situation demanding great activity.* She has been well since.

Case 8.—Tailor's helper; aged twenty-six; married. Dementia paralytica (depression). Improved. *The only reason for taking the patient away was that his wife wanted him at home.* He was later admitted to several hospitals in succession. In one of them he was diagnosed as psychoneurosis—neurasthenic type.

Case 9.—Housewife; aged thirty-five; married. Husband a traveling salesman. Chronic invalidism. Improved. The patient's husband took her home because she was *"homesick"*. A report four years later says: *"After return home* the patient was in practically the same condition as when she entered the hospital. It seemed impossible for her to get her mental processes on the right track. Finally she was *induced to become a Christian Scientist* and succeeded after some months in turning her thought away from herself through this route. She *now leads a much more normal life."*

Case 10.—Machine worker; aged forty-five; married. *Recurrent depression.* Improved. The patient was *taken home* by his wife—*no reason* given. He was soon admitted to a private sanitarium, where he was diagnosed melancholia. After a month's stay he was discharged home, to be readmitted later. He died after two years. The patient's wife stated that she had tried to keep him at home for a while, but he got so bad that he had to be taken to the private sanitarium. *On one occasion he tried to choke her.* After his death the patient's wife was *told that he died of paresis.*

Case 11.—Housewife; aged thirty-nine; married. Husband a driver. Reactive depression. Improved. The patient's *husband insisted upon taking the patient home "because there was no one to look after the baby".* "The baby cries all night and keeps us all awake." Arrangements were made to board the baby in a nursing home, but the husband would not consent to this. The patient felt that something unpleasant was going to happen and did not want to leave the clinic, but was forced to do so by her husband. A report six years later stated that the patient

has been *all right since leaving* the clinic. Her brother wonders "how she keeps from going crazy" with all that she had to stand from her husband and son (both alcoholic and abusive).

Case 12.—Woman; no occupation; aged thirty-eight; single. Depressive stupor with schizophrenic features. Unimproved. The patient's *family decided to take her home and have to stay with her the nurse who was discharged from the case for tying the patient in a continuous tub and leaving her, allowing the temperature of the water to get too high.* Five years later her aunt reports that the patient has been working.

Case 13.—Bookkeeper; aged thirty-five; married. Schizophrenic reaction type. Unimproved. The patient wrote a letter home pleading to be taken away from the clinic. He was suspicious of nurses and doctors. His *father claimed that nicotine,* which he had absorbed through his *excessive smoking, was producing the patient's symptoms.* The patient accepted this as the etiology of his illness. Six years later the father writes: "He is very much better than when in the clinic . . . would say that he is not more than a quarter as bad as he was at that time. He still feels somewhat depressed at times and that people do not care for him, but is cheerful most of the time."

Case 14.—Sheet-metal worker; aged fifteen; single. Manic-depressive reaction type. Unimproved. The patient was resistive, and his *father decided that all he needed was discipline and took him home.* The father could not be convinced that the patient had any mental disorder. The patient was later admitted to a municipal psychiatric hospital and to a private sanitarium. The diagnosis was constitutional psychopathic inferiority.

Case 15.—Schoolgirl; aged eighteen; single. Father a business man. Schizophrenic reaction type with affective features. Unimproved. Her *mother insisted upon taking the patient home, saying that the hospital had made the patient much worse* and that she could make her well. Three years later the father reports that the patient had apparently recovered. "The service of psychiatrics is in its infancy in my opinion, and, frankly, unless changes have been made in the methods practiced when my daughter was there with you, I think studies along the line of deeper soul thought would show better results with most patients."

Case 16.—Single girl; aged seventeen; no occupation. Father a clerk. Constitutional psychopathic inferiority. Unimproved. The patient's *mother* came in a distracted state. She *had promised the patient to take her home and did not want to break her word.* Five years later this mother reported: "I think I made one of the worst mistakes of my life in ever putting my dear daughter in any sanitarium. I sent her to Hopkins for observation and to be X-rayed to see if they could locate her trouble; of course the child was nervous and toxic all the time. But all that came from her kidneys . . . she knew she was nervous and toxic, but nothing the matter with her mind. . . . She has been sick and ailing ever since she left your place, but able to be around, only no vitality, and of a very nervous and temperamental temperament." The patient was later admitted to a sanitarium and died there.

Case 17.—Stenographer; aged twenty-four; single. Depressive reaction type with schizophrenic features. Unimproved. The patient was *taken home by her mother, who said that she* would never get well at the clinic and *might as well die at home.* The patient was later admitted to a psychopathic hospital. Diagnosis there: dementia praecox, catatonic.

Case 18.—Man; aged thirty-five; married; no occupation. Epileptic psychosis. Unimproved. The patient's *wife* was advised to place the patient in a state hospital, but she *determined to take him home when she learned that his own family would care for him at their home, if she did not.* The patient became gradually worse and had to be committed to a state hospital. The family is indignant because the patient's wife will not care for him at home.

Case 19.—Banker; aged forty-seven; married. Organic reaction type (arteriosclerosis). Unimproved. The *patient refused to stay on account of his wife's attitude; for example, jealousy of the nurse* (tried to get patient to complain about her in order to have her dismissed) and insinuations about the nurse, nagging of her husband, going to the ward without permission when requested to limit visits, listening outside of patient's door to conversations between nurse and patient and doctor and patient, and the like. A year and a half after leaving the clinic the patient wrote: "Health excellent; steadily at work; never felt better in my life, in every way."

Case 20.—Sheet-metal worker; aged thirty-two; married. Paranoid reaction type. Unimproved. *The patient was morbidly suspicious of his wife* and insisted on leaving. The family was strongly advised to commit him to a state hospital and not to take him home. Even when the wife and sister came for the patient, he became suspicious when the wife talked with the physician in his office and said: "What is she doing there?" *He was taken home against advice. Two days after discharge, he shot his wife several times* in the neck and hand. She was in a serious condition, but recovered. The patient was admitted to a state hospital.

Case 21.—Factory worker (woman); aged twenty-three; single. Depressive reaction type. Improved. The patient chafed under the hospital régime and was taken home by her mother and sister. About a month later she was brought back for readmission and a state hospital was advised; but she was taken to Washington to visit instead. Her condition grew worse. *The family was convinced that the patient was under a "spell"* and planned to take her to various women who could cure spells. A report three months later stated that the patient *went to numerous doctors, clairvoyants, and women who remove spells.* She was finally admitted to a state hospital.

Case 22.—Housewife; aged nineteen; married. Husband a carpenter. Anxiety neurosis with tension and tendency to invalidism. Improved. The patient was taken out by her husband to go home. Shortly after, the patient reported: "Not feeling very well yesterday, but now am taking Lydia Pinkham's Vegetable Compound. Do you ever think I will get well?" A report four years later: After leaving the clinic the

patient tried several doctors without improvement and finally *spent five weeks in a "hospital", where the colored doctor told her she would never be well until she had a child.* The patient still complains of forgetfulness and lack of concentration.

Case 23.—Married woman; aged forty-one. Husband an electrician. Recurrent depression. Unimproved. Her *husband took the patient away* from the hospital to stay with the family at home. The patient stated on leaving that she had been well taken care of in the clinic and had learned a good lesson—how foolish it was to take her own life. (She had made many suicidal attempts before entering the clinic.) *One week after discharge, however, the patient attempted suicide* by choking herself and by trying to swallow hairpins. She was committed to a state hospital.

Case 24.—Draftsman; aged twenty-nine; married. Alcoholic hallucinosis with schizophrenic features. Slightly improved. The patient was very restless, and his *father encouraged him in his desire to go home.* Report the next year: The patient's wife felt that the patient should be in an institution, but his father insisted that he remain at home. *Since the father furnished the support for the family, the wife did not feel that she could take independent action* in the matter. She cried when telling this, saying that the patient was brought home against her wish. *The patient* had recently *twice threatened to shoot his wife.* He was finally committed to a state hospital. Diagnosis: paranoid dementia praecox. The patient was unhappy there and was taken home by his father after several weeks. The father "could not stand it". The father says that the patient's wife is quarrelsome and "nags her husband to death. I am more afraid of her than of him; he would never hurt any one."

Case 25.—Housewife; aged thirty; married. Husband a laborer. Schizophrenic reaction type. Constitutional inferior. Unimproved. The patient was taken home by her husband. On one occasion during the husband's visit, which lasted through the patient's supper time, he became disturbed when the nurse was urging the patient to eat. The patient whimpered and protested, but ate with no special resistance when food was put into her mouth. Her *husband interfered. He said that she had always been difficult to feed and our expecting her to eat was all wrong. It would make her sick.* Three years later the patient stated that she was well.

Case 26.—Housewife; aged twenty-two; married. Confusional state (toxic). Etiology not determined. Improved. *The patient was taken home by her husband, no reason being given.* Following discharge, the patient boarded with her parents. Her husband preferred this as he was "still afraid of her and wanted to feel sure that she was all right before going to housekeeping again". While admitting the strange behavior of the patient, both her husband and her family refused hospital care, but had a private physician until a year later. At that time *the patient's mother-in-law reported that the patient had been brought to her home by the patient's own father, who refused to keep her. The patient's back was black and blue from their beatings in effort to control*

her. The family was so afraid of her that they locked their doors at night. The patient was committed to a state hospital; paroled improved shortly after. Diagnosis: dementia praecox, simple type.

Case 27.—Housewife; aged thirty-seven; married. Husband in the insurance business. Schizophrenic reaction type with some hysterical features. Unimproved. *Her husband said that the chief reason for taking the patient home was that she felt that the medicine and treatment she had received were responsible for her nervous breakdown. After leaving* the clinic, the patient was at home for a month and was then *taken to an osteopathic sanitarium because she threatened to kill the children.* She remained there six months and was greatly improved. She still complained of noises in her head and could "almost hear voices" at times. She gained no insight into her delusions concerning the hospital.

Case 28.—Schoolboy; aged fifteen; single. Constitutional psychopathic personality. Unimproved. *The mother of the patient had been in the clinic several years before. Diagnosis: depression; paranoid personality. She got excited and criticized the methods and personnel before the patient.* She demanded his release because "she cannot trust the nurses and orderlies on the ward". She took him out in an ambulance, but would not say where. A report three months later stated that the patient had been taken ill in a cell at the police station, and was operated on at a general hospital for acute appendicitis. He had been arrested two days before because he had been seen loitering around the wharves for several nights. He said that he was trying to get aboard one of the boats to run away from home. Five months later he packed up his possessions and many belongings of other people and disappeared. There was no trace of him for months. Found and brought back home, he soon *attacked his father with a carving knife* and cut him from forehead to throat. He was placed on the quiet ward of a state hospital. There he jammed another patient's hat down over his face so hard it took two men to pull it off. He was placed in the disturbed ward. *He escaped from the state hospital.* Found six months later and returned to the state hospital, he *escaped again and was not found at the last report* (1926).

Case 29.—Laborer; aged twenty-one; single. Manic-depressive reaction type, manic phase. Improved. The patient was taken home by his mother, no reason being given. A year later the patient was reported as quite well since leaving the clinic. The patient said: "Haven't had any notions since I left, but I still bite my finger nails." The family is very superstitious. *His mother hints that a spell had been cast on the patient by some girl:* "Such things do happen—just a few days ago a girl threw a bottle overboard that had needles and pins in it."

Case 30.—Housewife; aged forty; separated from her husband. Paranoid flurry in constitutional psychopathic personality. Unimproved. No reason was given for leaving the hospital. A report two years later: After leaving the clinic the patient spent some months with her sister. She went to a *faith healer, "not the one who had cast a spell on her",* and he *soon cured her of all her complaints.*

Case 31.—Housewife; aged thirty-seven; married. Constitutional psychopathic personality. Depressive reaction with anxiety. Slightly improved. On account of the *paranoid condition of her husband* and in view of troublesome conditions caused by him, it was suggested that the patient be admitted to a state hospital. The husband disregarded this advice and took the patient home, despite the fact that he was warned of the patient's three suicidal attempts and her present suicidal tendencies. The *following year* a letter was received from the husband, telling of a *suicidal attempt* with "bichloride or some other such junk". The patient was later admitted to a sanitarium.

Case 32.—Housewife; aged forty; married. Agitated depression. Improved. When alone, she was often very restless, pacing the floor and muttering to herself under her breath, "Oh, my God!" When this was discussed with her, she explained that it was the distress of being kept in the clinic. Her *husband* was advised to place her in another hospital. The suicidal risks were explained to him, but he felt that he was *willing to take the risk at home* on the chance that removal from the hospital might produce an improvement. A letter from the patient's husband brought word that the patient had died about nine months after discharge: "For a short while after leaving the hospital she seemed to have sufficient grip on herself to come out of it. But she *gradually began to starve herself* and kept this up until she was very thin and had very little strength. Some way or another *she managed to obtain a bottle of veronal.* Of course she took all ten tablets at once. Although she had taken as much several times during her illness, she was in such a weakened condition this time that it *proved too much for her heart.* . . . If she could not recover at Johns Hopkins Hospital, we felt that no hospital could help her much. Her death was a great relief to her long mental suffering of over two years."

Case 33.—Secretary; aged twenty-seven; single. *Schizophrenic reaction type with catatonic stupor episodes.* Unimproved. For several weeks before discharge the patient had been insisting upon leaving and she promised her family to do anything and everything they said. The *family physician reported a year later: Saw the patient the day after her discharge* and *was "amazed". She seemed mentally "perfectly clear and marvelously well".* Mental condition has continued good and behavior normal. She has not attempted to work yet.

Case 34.—Schoolgirl; aged sixteen; single. Constitutional psychopathic inferiority. Unimproved. The patient had been *"admitted after a number of sex delinquencies.* Her *mother took her home* instead of to another institution, as advised. A report the following year yielded the following information: After six weeks the patient ran away from home. She was *found in another city in a disorderly house.* She had *married a shady individual much older than herself.* She was taken to a corrective institution. There she seemed to make excellent progress, but her *mother took her home again against the advice of physicians.*

SUMMARY

1. The ever wider extension of psychopathology into the field of the social sciences makes it the duty of psychiatry to investigate the social problems that are most closely related to the narrower field of psychiatry.

2. During a period of eight years (1918–1926), 2,758 patients were discharged from the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, according to medical routine. During the same period 193 patients, or 6.54 per cent of the total discharges, were discharged against medical advice.

3. As regards the distribution of diagnoses in these cases, there is a predominance of depressions (73) and a relatively large number of cases of general paresis (17). Manic excitement (4) and paranoid psychosis (2) are infrequent. This would indicate that the social environment of a patient does not easily recognize the milder manifestations of depression as morbid. In elated conditions, on the other hand, the environment takes a very serious view of the patient's condition. The large number of cases of general paresis is connected with the fact that, due to its characteristic symptomatology, the patient and his environment frequently have little insight into the seriousness of the condition.

4. In 146 of 193 cases, the attitude of the family was the main problem of the physician, as compared with 26 cases in which the initiative could be solely and entirely attributed to the patient. In 10 cases the patient was taken from the clinic by his family expressly against his wishes.

5. In a very considerable number of cases the reasons given by the family had very little to do with the patient's sickness and treatment, except in so far as it caused a separation of the patient from his family. For example, a husband wanted his wife at home because the baby disturbed him by crying at night; and so forth.

6. In a number of cases there was a division in the family—most frequently in the form of husband vs. wife's relatives and vice versa. This division should receive the attention of the physician even before the emergency of the discharge against advice brings it especially to his notice.

7. Out of 172 patients from whom information as to their

further career was obtained, 64 had apparently made satisfactory adjustment outside of mental hospitals (satisfactory being, of course, a very relative statement); 60 were readmitted to mental hospitals; 8 committed suicide; 6 made homicidal attempts; 8 made suicidal attempts.

8. The fact that a difference in opinion often arises between the physician and the layman on the occasion of discharges against medical advice should make it the duty of the physician to explain to the family the psychopathological condition, the treatment, and the social consequences much more clearly than is done customarily.

9. In some cases the further fate of the patient did not bear out the prognosis made by the physician. This should be a warning against too fixed and formal prognoses as against a careful evaluation of the social environment to which the patient returns (social prognosis). In a few cases what seemed from the physician's point of view an undesirable discharge proved salutary—for example, the case of a woman suffering from a diagnostically unclear auditory hallucinosis, which cleared up when the patient was precipitated at home into a situation demanding great activity. On the whole, the dangers of discharge against advice seem to be overestimated.

10. It is indicated by the findings of this study that in its social aspect mental disease is not a problem only of the individual and the community in general; between them the family is interpolated as a decisive entity. In general, the statement seems justifiable that when the relationship between the family and the physician comes to be regarded as forming an essential part of psychopathology, the extension of the organization of psychiatric hospitals with wards for only voluntary admissions seems practicable and desirable.

RECENT STATISTICS OF ALCOHOLIC MENTAL DISEASE

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IN view of the widespread interest in the enforcement of the prohibition laws and in the liquor problem in general, the authors have deemed it wise to supplement and bring up to date as nearly as possible the data contained in a study on prohibition and alcoholic mental disease by Horatio M. Pollock and Edith M. Furbush, which was published in *The American Review* and in MENTAL HYGIENE in 1924.[1]

In preparing this supplementary study, data have been compiled from three principal sources, namely: The Statistical Bureau of the New York State Department of Mental Hygiene, the Department of Information and Statistics of The National Committee for Mental Hygiene, and the Federal Census Bureau. The data at each source were compiled from original schedules filled out in accordance with uniform instructions by the reporting institutions.

ALCOHOLIC MENTAL DISEASE IN NEW YORK STATE

The Statistical Bureau of the New York State Department of Mental Hygiene has collected in uniform manner data relating to alcoholic mental disease and the use of alcohol by first admissions to the civil state hospitals each year since 1909.

The record with respect to new cases of alcoholic mental disease in relation to all first admissions is shown in Table 1. The twenty years covered by this table may, with

[1] "Prohibition and Alcoholic Mental Disease", by Horatio M. Pollock and Edith M. Furbush. *The American Review*, Vol. 2, pp. 142–54, March-April, 1924, and MENTAL HYGIENE, Vol. 8, pp. 548–70, April, 1924.

reference to the trend of the alcoholic cases, be separated into four rather distinct periods. The first period includes the years 1909–1913, when the new alcoholic cases numbered

TABLE 1. NEW CASES OF ALCOHOLIC MENTAL DISEASE ADMITTED TO CIVIL STATE HOSPITALS OF NEW YORK, 1909-1928

FISCAL YEAR ENDED	TOTAL NEW CASES, ALL PSYCHOSES	NEW CASES OF ALCOHOLIC MENTAL DISEASE					
		Number			*Per cent of all new cases*		
		Males	Females	Total	Males	Females	Total
1909	5,222	433	128	561	15.6	5.8	10.8
1910	5,564	452	131	583	15.3	5.0	10.5
1911	5,700	444	147	591	14.7	5.5	10.4
1912	5,742	434	131	565	14.4	4.8	9.8
1913	6,061	438	134	572	13.7	4.7	9.4
1914	6,265	348	116	464	10.4	3.6	7.4
1915	6,204	255	90	345	7.8	3.1	5.6
1916*	4,903	215	82	297	8.4	3.5	6.1
1917	6,877	437	157	594	12.1	4.8	8.6
1918	6,797	257	97	354	7.3	3.0	5.2
1919	6,791	204	65	269	5.8	2.0	4.0
1920	6,573	90	32	122	2.7	1.0	1.9
1921	6,939	167	26	193	4.6	0.8	2.8
1922	7,015	194	32	226	5.1	1.0	3.2
1923	6,900	220	56	276	6.1	1.7	4.0
1924	6,933	302	71	373	8.2	2.2	5.4
1925	7,435	341	81	422	8.8	2.3	5.7
1926	7,295	333	89	422	8.4	2.7	5.8
1927	7,928	440	114	554	10.1	3.2	7.0
1928	8,614	430	79	509	9.1	2.0	5.9

*9 Months.

from 561 to 591, and the percentages varied from 9.4 to 10.8. The second period covered the years 1914–1917, during the first three of which there was a decided reduction in the number and percentage of the alcoholic cases. In the year 1917 a reaction occurred, probably due to the entrance of this country into the World War. The number of alcoholic first admissions in that year was 594, the largest number in the history of the New York State hospital system. The third period, running from 1918 to 1921, witnessed a remarkable decline in alcoholic cases. The low point was reached in 1920, when the number was only 122 and the percentage 1.9. The fourth and final period covers the years from 1922

to 1928. In this period the trend of alcoholic cases has been upward, but a slight downward reaction occurred in 1928. Whether such reaction is the beginning of a new trend or merely a slight divergence in the upward movement will be later revealed.

Although there are comparatively few women in the alcoholic group, the decline among them since 1910 has been relatively greater than among men.

The influence of alcohol in the causation of mental disease of various kinds is indicated, to some extent at least, by the percentage of intemperate users of alcohol among first admissions. A record of such use has been regularly made by the state hospitals on statistical schedules since 1909. Data compiled directly from such schedules for the past twenty years are set forth in Table 2.

TABLE 2. INTEMPERATE USE OF ALCOHOL AMONG FIRST ADMISSIONS TO CIVIL STATE HOSPITALS OF NEW YORK, 1909-1928

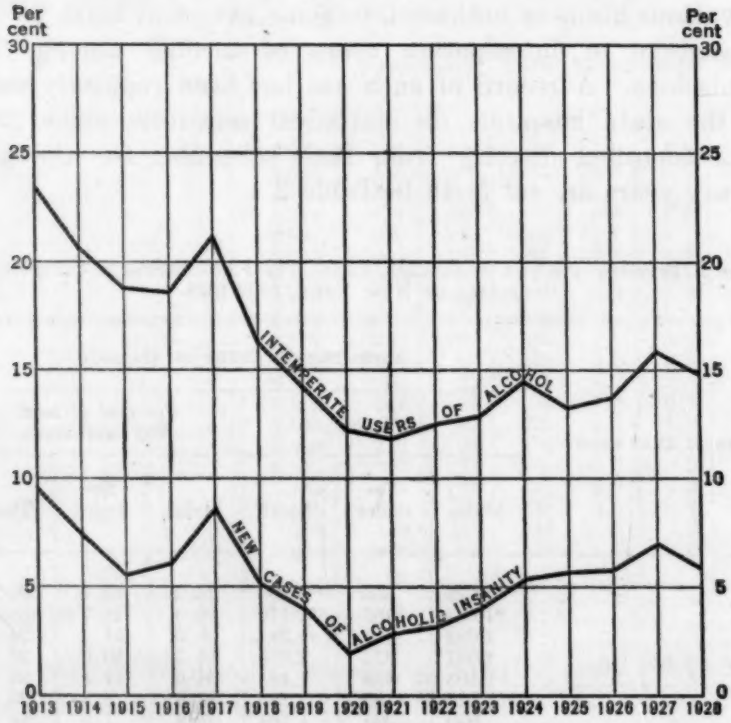
FISCAL YEAR ENDED	INTEMPERATE USERS OF ALCOHOL					
	Number			*Per cent of total first admissions*		
	Males	Females	Total	Males	Females	Total
1909	1,229	369	1,598	44.2	15.1	28.7
1910	*1,684	*488	*2,172	56.9	28.7	38.1
1911	1,082	302	1,384	35.9	11.2	24.3
1912	1,097	273	1,370	36.5	10.0	23.8
1913	1,103	318	1,421	34.6	11.1	23.5
1914	1,027	258	1,285	30.8	8.8	20.5
1915	939	225	1,164	28.8	7.5	18.7
1916 (9 months)	725	182	907	28.2	7.8	18.5
1917	1,152	300	1,452	32.0	9.2	21.1
1918	851	253	1,104	24.1	7.7	16.2
1919	804	161	965	22.8	4.9	14.2
1920	684	119	803	20.3	3.7	12.2
1921	691	131	822	18.9	4.0	11.8
1922	757	122	879	21.1	3.8	12.5
1923	756	130	886	20.9	4.0	12.8
1924	842	165	1,007	22.8	5.1	14.5
1925	813	167	980	21.0	4.5	13.2
1926	832	170	1,002	21.0	5.1	13.7
1927	1,050	211	1,261	24.1	5.9	15.9
1928	1,094	191	1,285	23.2	4.9	14.9

*Includes moderate drinkers.

The trends shown in this table correspond closely with those shown in Table 1, although the variations from period to period are relatively not quite so marked. This is well shown in Chart 1 which covers the years 1913 to 1928. The dip in the trends in 1928 may or may not be significant.

CHART 1

CASES OF ALCOHOLIC MENTAL DISEASE AND INTEMPERATE USERS OF ALCOHOL AMONG NEW ADMISSIONS TO NEW YORK CIVIL STATE HOSPITALS, 1913–1928



ALCOHOLIC MENTAL DISEASE IN 19 STATES

In their study of prohibition and alcoholic mental disease,[1] Pollock and Furbush made use of the uniform statistical reports received by The National Committee for Mental Hygiene for the year 1922. These reports were received from 98 state hospitals for mental disease, distributed as follows:

[1] Op. cit.

California	6	New Jersey	2
Colorado	1	New York	15
Connecticut	2	Ohio	8
Georgia	1	Oregon	1
Illinois	9	Pennsylvania	6
Indiana	4	Rhode Island	1
Iowa	4	South Carolina	1
Louisiana	2	South Dakota	1
Maine	2	Tennessee	1
Maryland	2	Texas	1
Massachusetts	13	Vermont	1
Michigan	5	Virginia	3
Mississippi	1	Washington	1
Nebraska	2	Wyoming	1
New Hampshire	1		

For that study complete data—that is, reports from every state hospital in the state—were received from 19 states, having a total of 80 hospitals.

In the present study, data for the same group of hospitals for the years 1925 and 1926 are compared with those for 1922, and data from smaller groups are compared with those for states from which complete returns were available for the years 1910, 1919, and 1921.

As stated in the previous study, "the wide geographical distribution, the fact that the group of hospitals is unselected, and the large number of patients included, make the data representative of the country as a whole".

New Admissions to State Hospitals. — The term "new admissions" refers to all patients admitted for the first time to any hospital for the treatment of mental disease, except institutions for temporary care only.

Detailed figures showing the number of males and females, the total number of all new admissions, and the rate of new admissions per 100,000 of the general population of each of the 19 states, for the years 1922, 1925, and 1926, are given in Table 3 (page 596). These figures may be summarized as follows:

			Total	
Year	*Males*	*Females*	Number	Rate per 100,000
1922	16,807	12,408	29,215	50.5
1925	16,842	12,835	29,677	48.5
1926	16,855	12,683	29,538	47.6

TABLE 3. NUMBER OF NEW ADMISSIONS TO STATE HOSPITALS FOR MENTAL DISEASE AND RATE PER 100,000 GENERAL POPULATION IN 19 STATES FOR THE YEARS 1926, 1925 AND 1922.

States	1926				1925				1922			
			Total				Total				Total	
	Males	Females	Number	Rate per 100,000	Males	Females	Number	Rate per 100,000	Males	Females	Number	Rate per 100,000
California	1,782	1,097	2,879	66.7	1,940	1,030	2,970	71.1	1,773	947	2,720	73.6
Colorado	241	152	393	37.1	210	145	355	34.1	264	159	423	43.3
Connecticut	552	388	940	58.4	451	375	826	52.6	464	399	863	59.6
Georgia	476	478	954	30.4	520	434	954	30.8	335	317	652	22.0
Illinois	2,768	1,619	4,387	60.9	2,754	1,674	4,428	62.4	2,970	1,822	4,792	71.5
Iowa	536	333	869	35.9	515	412	927	38.3	531	393	924	37.7
Louisiana	313	249	562	29.3	291	257	548	28.8	317	272	589	32.1
Maine	186	172	358	45.5	217	156	373	47.4	210	120	330	42.6
Massachusetts	1,455	1,359	2,814	67.0	1,520	1,344	2,864	69.1	1,743	1,531	3,274	82.3
New Hampshire	203	155	358	78.9	166	172	338	74.9	186	130	316	70.8
New Jersey	719	549	1,268	34.5	781	624	1,405	39.0	732	618	1,350	40.7
New York	4,091	3,337	7,428	65.7	4,004	3,580	7,584	67.9	3,922	3,247	7,169	66.9
Ohio	1,769	1,349	3,118	47.2	1,703	1,279	2,982	46.1	1,650	1,027	2,857	47.5
Pennsylvania	997	788	1,785	18.6	980	725	1,705	18.0	888	671	1,559	17.3
Rhode Island	198	196	394	56.9	212	156	368	54.2	201	143	344	55.5
South Carolina	317	284	601	32.9	296	315	611	33.9	371	278	649	37.6
South Dakota	129	95	224	32.5	159	74	233	34.2	117	82	199	30.6
Vermont	89	62	151	42.9	91	66	157	44.6	89	57	146	41.4
Wyoming	34	21	55	23.4	32	17	49	21.4	44	15	59	28.5
Total	16,855	12,683	29,538	47.6	16,842	12,835	29,677	48.5	16,807	12,408	29,215	50.5

A very slight increase is noted among the males, there being 35 more in 1925 than in 1922 and 13 more in 1926 than in 1925. Among the females there was an increase of 427 from 1922 to 1925, and a decrease of 142 from 1925 to 1926. The net increase from 1922 to 1925 was, therefore, 48 males and 285 females, or a total of 333, the increase in females being approximately six times that of the males. There were 133 males to every 100 females among the new admissions in 1926, the ratio being considerably larger than that of males to females in the general population, which the last census gave as 104 males to every 100 females. Between 1922 and 1926 there was an increase in the number of male new admissions in 10 states, and in the number of female in 12.

The extent of state institutional care of persons suffering from mental disease is best indicated by the rate per 100,000 of general population. For the entire group of states this rate decreased by 2.0 from 1922 to 1925 and by 0.9 from 1925 to 1926, a total decrease of 2.9 from 1922 to 1926. The seven states having the highest rate per 100,000 were New Hampshire, Massachusetts, California, New York, Illinois, Connecticut, and Rhode Island. In all of these states more than 60 per cent of the population live in urban districts. The lowest rates, on the other hand, occur in those states whose population is predominantly rural. Pennsylvania, whose rate per 100,000 in the table is the lowest of all the states in each of the three years, must be considered separately, in as much as a great many of its mental patients are cared for in county institutions.

Cases of Alcoholic Mental Disease Among New Admissions.—The number of new cases of alcoholic mental disease and the per cent they constitute of all new admissions to the hospitals of 19 states are given in Table 4 (page 598). The percentages for males and females indicate percentages of all new male and female admissions respectively. The total figures and the percentages for the entire group of states are:

	Number			*Per cent*		
Year	Males	Females	Total	Males	Females	Total
1922	1,027	124	1,151	6.1	1.0	3.9
1925	1,279	182	1,461	7.6	1.4	4.9
1926	1,369	206	1,575	8.1	1.6	5.3

TABLE 4. CASES OF ALCOHOLIC INSANITY AMONG NEW ADMISSIONS TO THE STATE HOSPITALS FOR MENTAL DISEASE IN 19 STATES FOR THE YEARS 1926, 1925, AND 1922.

STATE	NEW CASES OF ALCOHOLIC INSANITY																	
	1926						1925						1922					
	Number			*Per cent of all new admissions*			*Number*			*Per cent of all new admissions*			*Number*			*Per cent of all new admissions*		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
California	108	18	126	6.1	1.6	4.4	116	12	128	6.0	1.2	4.3	109	10	119	6.1	1.1	4.4
Colorado	1	...	1	0.4	...	0.3	2	...	2	0.9	...	0.6	3	...	3	1.1	...	0.7
Connecticut	71	11	82	12.9	2.8	8.7	54	7	61	12.0	1.9	7.4	40	1	41	8.6	0.3	4.8
Georgia	14	...	14	2.9	...	1.5	11	1	12	2.1	0.2	1.3	5	1	6	1.5	0.3	0.9
Illinois	270	28	298	9.8	1.7	6.8	223	26	249	8.1	1.6	5.6	224	28	252	7.5	1.5	5.3
Iowa	26	...	26	5.0	...	3.0	30	3	33	6.0	0.7	3.6	24	2	26	4.5	0.5	2.8
Louisiana	2	...	2	0.6	...	0.4	1	3	4	0.3	1.2	0.7	5	...	5	1.6	...	0.8
Maine	11	...	11	5.9	...	3.1	18	1	19	8.3	0.6	5.1	14	...	14	6.7	...	4.2
Massachusetts	161	25	186	11.1	1.8	6.6	158	17	175	10.4	1.3	6.1	180	35	215	10.3	2.3	6.6
New Hampshire	15	2	17	7.4	1.3	4.7	11	1	12	6.6	.6	3.6	19	2	21	10.2	1.5	6.6
New Jersey	70	3	73	9.7	0.5	5.8	80	8	88	10.1	1.3	6.3	50	5	55	6.8	0.8	4.1
New York	343	89	432	8.4	2.7	5.8	347	82	429	8.7	2.3	5.7	209	32	241	5.3	1.0	3.4
Ohio	133	17	150	7.5	1.3	4.8	103	7	110	6.0	0.5	3.7	60	4	64	3.6	0.3	2.2
Pennsylvania	82	6	88	8.2	0.8	4.9	67	4	71	6.8	0.6	4.2	42	1	43	4.7	0.1	2.8
Rhode Island	44	5	49	22.2	2.6	12.4	39	8	47	18.4	5.1	12.8	32	2	34	15.9	1.4	9.9
South Carolina	9	...	9	2.8	...	1.5	7	...	7	2.4	...	1.1	5	1	6	1.3	.4	0.9
South Dakota	4	...	4	3.1	...	1.8	4	...	4	2.5	...	3.0	2	...	2	1.7	...	1.0
Vermont	1	...	1	1.1	...	1.6	3	...	3	3.3	...	1.9	1	...	1	1.1	...	0.7
Wyoming	4	2	6	11.8	9.5	10.9	5	2	7	15.6	11.8	14.3	3	...	3	6.8	...	5.1
Total	1,369	206	1,575	8.1	1.6	5.3	1,279	182	1,461	7.6	1.4	4.9	1,027	124	1,151	6.1	1.0	3.9

These figures show a small, but significant increase in both the number and percentage of alcoholic cases among new admissions.

The ratio of male to female patients with alcoholic psychoses is of interest. In 1922 there were approximately 6 males to every female; in 1925 the ratio was practically the same; and in 1926 it increased to approximately 7.5 to 1.

Within the different states considerable variation is to be noted in the percentages of alcoholic cases, ranging in 1922 from 9.9 per cent in Rhode Island to 0.7 per cent in Colorado and Vermont; in 1925, from 14.3 per cent in Wyoming to 0.6 per cent in Colorado; and in 1926, from 12.4 per cent in Rhode Island to 0.3 per cent in Colorado. Similar wide variations occur among the male and female patients, there being several states with no female alcoholic patients.

It is also of interest to note that by far the largest number of alcoholic patients are in states predominantly urban in their population. The 1920 Federal Census gives the following percentages of urban population for the states noted: California, 68; Connecticut, 67.7; Illinois, 67.9; Massachusetts, 94.8; New Jersey, 78.4; New York, 82.7; Ohio, 63.8; Pennsylvania, 64.3; and Rhode Island, 97.5. These states have more than 90 per cent of both the male and female alcoholic cases.

A further comparison of the individual states indicates that alcoholic psychoses are much more prevalent in those states that were "wet" before the national prohibition law went into effect than in those that were "dry". Of the 9 states just listed as having more than 90 per cent of all alcoholic cases, all were "wet" before prohibition, while all of the others, with the single exception of Vermont,[1] were either "bone dry" or had state-wide restrictions on the sale and use of alcoholic beverages which placed them in the "dry" column.

Alcoholic Cases Among All Admissions.—A comparison of the percentages of alcoholic cases among all admissions for 1926, 1925, 1922, and 1910, including readmissions as well as those admitted for the first time, is made possible by the use of data furnished by the Federal Census Bureau for

[1] Vermont was dry part of the time before prohibition.

1910. Although the 1910 survey includes figures for private as well as state hospitals, their influence is so slight as to affect the comparison very little if at all. These percentages for the 19 states are as follows:

State	*1926*	*1925*	*1922*	*1910*
California	4.2	4.2	4.3	13.0
Colorado	0.2	0.5	0.7	20.8
Connecticut	9.2	6.8	4.8	10.6
Georgia	1.4	1.3	0.9	5.1
Illinois	6.4	5.9	5.1	8.9
Iowa	1.0	1.4	3.0	6.9
Louisiana	0.4	0.6	0.7	8.1
Maine	3.4	4.8	4.0	6.5
Massachusetts	6.2	6.3	6.4	14.6
New Hampshire	4.7	3.4	6.6	11.3
New Jersey	5.8	6.6	4.3	19.7
New York	5.4	5.3	3.2	11.5
Ohio	4.6	3.7	2.1	12.4
Pennsylvania	4.6	4.3	3.0	6.9
Rhode Island	11.7	12.4	9.8	11.4
South Carolina	1.3	1.2	0.8	5.7
South Dakota	1.4	1.3	0.8	0.5
Vermont	1.9	1.3	1.5	11.1
Wyoming	8.2	11.1	5.8	14.3
Total	5.1	4.8	3.9	11.0

It will be noted that for the entire group the percentage dropped from 11.0 in 1910 to 3.9 in 1922, and that since 1922 there has been a slight increase, the 1926 percentage, however, being less than one-half that of 1910. The percentages for the three years 1926, 1922, and 1910, are further compared in Chart 2 (page 601).

Prevalence of Alcoholic Mental Disease.—The actual prevalence of alcoholic mental disease is probably best indicated by the number of alcoholic psychoses per 100,000 of general population. A comparison of the number of new cases per 100,000 of general population for the years 1919, 1922, 1925, and 1926 should indicate the general trend of the disease since the advent of prohibition. Complete data for these four years were received from 12 states, comprising 43 hospitals. The number of alcoholic cases among the new admissions to the hospitals of these states and the rate per

CHART 2

CASES OF ALCOHOLIC INSANITY AMONG ALL ADMISSIONS TO THE HOSPITALS FOR MENTAL DISEASE IN 19 STATES DURING 1910, 1922, AND 1926

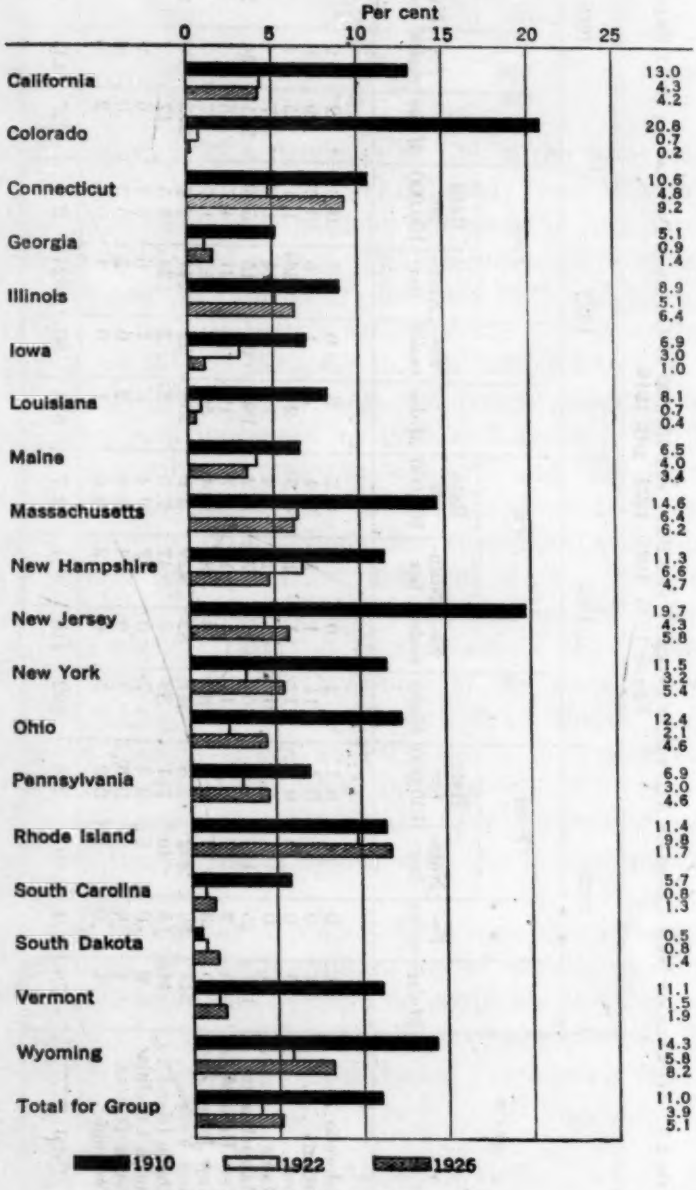


TABLE 5. NUMBER OF NEW CASES OF ALCOHOLIC INSANITY AND RATE PER 100,000 OF GENERAL POPULATION IN 12 STATES FOR THE YEARS 1926, 1925, 1922, AND 1919.

STATE	1926				1925				1922				1919			
			Total				*Total*				*Total*				*Total*	
	Males	*Females*	Number	Rate per 100,000	*Males*	*Females*	Number	Rate per 100,000	*Males*	*Females*	Number	Rate per 100,000	*Males*	*Females*	Number	Rate per 100,000
Colorado	1	0	1	0.1	2	0	2	0.2	3	0	3	0.3	2	0	2	0.2
Georgia	14	0	14	0.4	11	1	12	0.4	5	1	6	0.2	9	0	9	0.3
Iowa	5	0	5	0.2	12	1	13	0.5	24	2	26	1.1	25	1	26	1.1
Maine	11	0	11	1.4	18	1	19	2.4	14	0	14	1.8	17	1	18	2.3
Massachusetts	161	25	186	4.4	158	17	175	4.2	180	35	215	5.4	241	54	295	7.7
New Hampshire	15	2	17	3.7	11	1	12	2.7	19	2	21	4.7	15	1	16	3.6
New Jersey	70	3	73	2.0	80	8	88	2.4	50	5	55	1.7	77	7	84	2.7
New York	343	89	432	3.8	347	82	429	3.9	209	32	241	2.2	216	69	285	2.8
Rhode Island	44	5	49	7.1	39	8	47	7.0	32	2	34	5.5	17	2	19	3.2
South Carolina	9	0	9	0.5	7	0	7	0.4	5	1	6	0.3	6	0	6	0.4
South Dakota	4	0	4	0.6	4	0	4	0.6	2	0	2	0.3	0	0	0	0.0
Vermont	1	0	1	0.3	3	0	3	0.9	1	0	1	0.3	2	0	2	0.6
Total	678	124	803	2.6	692	119	811	2.7	544	80	624	2.2	627	135	762	2.7

100,000 of general population are given in Table 5 (page 602), which may be here summarized:

Year	Males	Females	Total	
			Number	Rate per 100,000
1919	627	135	762	2.7
1922	544	80	624	2.2
1925	692	119	811	2.7
1926	678	124	803	2.6

From 1919 to 1922 a decrease of 138 in the total number and of 0.5 in the rate per 100,000 is noted; from 1922 to 1925 the number of cases increased by 187 and the rate returned to 2.7 as in 1919; and a very slight decrease of 8 in number and 0.1 per cent in rate occurs between 1925 and 1926. The proportion of male to female cases for the four years respectively was 4.6 to 1 in 1919, 6.8 to 1 in 1922, 5.8 to 1 in 1925, and 5.5 to 1 in 1926. Both male and female cases decreased in 1922 and both increased in 1925 and again in 1926, but whereas the number of males in both 1925 and 1926 is greater than in 1919, the number of females in these two years is still less than in 1919. Numerous variations are noted in both numbers and rates for different states, those states with the largest urban population, Maine in 1925 excepted, having the highest rate. A comparison of the figures for 1926 and 1919 shows that one-half of the states—Georgia, New Hampshire, New York, Rhode Island, South Carolina, and South Dakota—have an increase in both number and rate and the others a decrease in both. Chart 3 (page 604) shows the comparative total rates per 100,000 of general population for the eight states with the largest number of alcoholic psychoses.

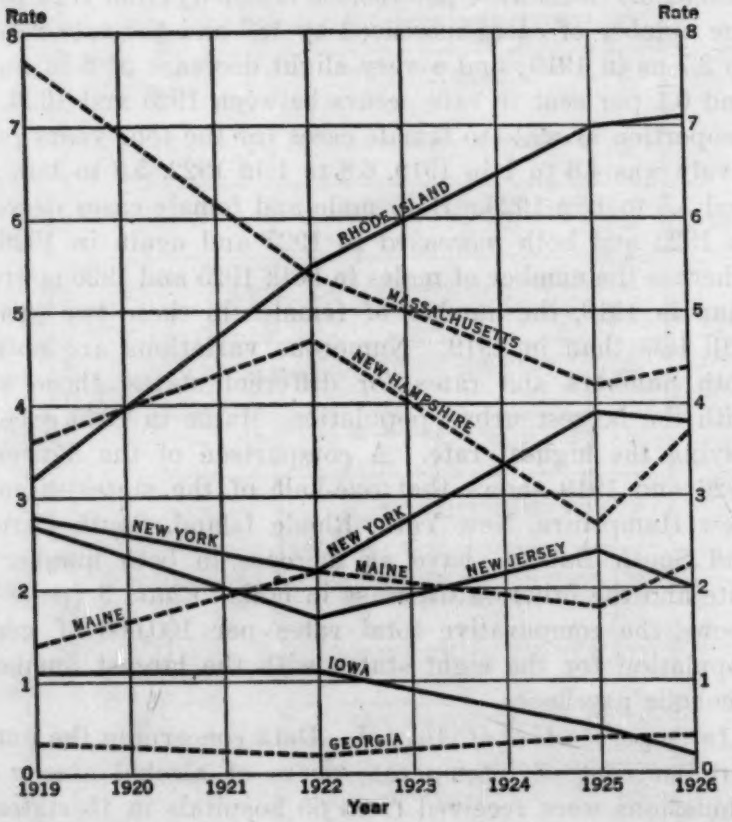
Intemperate Use of Alcohol.—Data concerning the number and per cent of intemperate users of alcohol among new admissions were received from 65 hospitals in 15 states for the years 1921, 1922, 1925, and 1926, and are given in Table 6 (page 605), the totals for the different years being as follows:

Year	Number			Per cent		
	M	F	T	M	F	T
1921	2,379	322	2,701	11.3	1.5	12.8
1922	2,647	357	3,004	11.9	1.6	13.5
1925	2,720	433	3,153	11.9	1.9	13.8
1926	2,774	452	3,226	12.2	2.0	14.2

A continual increase in both number and per cent is noted for each of the years for which data were obtained, except for the percentage of males in 1925, the states with a high percentage of urban population again furnishing the largest number, with the rural states of Colorado in 1921 and 1926,

CHART 3

RATE OF NEW CASES OF ALCOHOLIC MENTAL DISEASE PER 100,000 OF GENERAL POPULATION IN 8 STATES FOR THE YEARS 1919, 1922, 1925, AND 1926



Maine in 1921, 1922, and 1925, and South Carolina in 1921 and 1922 joining them. The marked variations that appear may be due, in some cases, to variations in methods of reporting the use of alcohol among new admissions.

The intemperate use of alcohol, while it is the direct cause of alcoholic psychoses, is likewise recognized as a contribut-

TABLE 6. INTEMPERATE USERS OF ALCOHOL AMONG ALL NEW ADMISSIONS TO THE 63 STATE HOSPITALS IN 15 STATES DURING 1926, 1925, 1922, AND 1921, BY SEX, NUMBER AND PER CENT OF ALL NEW ADMISSIONS.

STATE	1926						1925						1922						1921					
	Intemperate users of alcohol			*Per cent of all new admissions*			*Intemperate users of alcohol*			*Per centof all new admissions*			*Intemperate users of alcohol*			*Per cent of all new admissions*			*Intemperate users of alcohol*			*Per cent of all new admissions*		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
California...	263	41	304	9.1	1.4	10.5	318	38	356	10.7	1.3	12.0	362	33	395	13.3	1.2	14.5	347	25	372	14.1	1.0	15.1
Colorado....	47	6	53	11.9	1.5	13.4	31	7	38	8.7	1.9	10.6	32	4	36	7.6	0.9	8.5	51	3	54	11.2	0.7	11.9
Connecticut.	174	24	198	18.5	2.6	21.1	129	34	163	15.6	4.1	19.7	151	17	168	17.5	2.0	19.5	131	18	149	16.0	2.2	18.2
Maine	38	2	40	10.6	0.6	11.2	57	6	63	15.3	1.6	16.9	53	6	59	16.1	1.8	17.9	49	7	56	12.3	1.8	14.1
Massachusetts	359	68	427	12.8	2.4	15.2	387	71	458	13.5	2.5	16.0	396	85	481	12.1	2.6	14.7	293	61	354	11.5	2.4	13.9
N.Hampshire	44	2	46	12.3	0.6	12.9	40	6	46	11.8	1.8	13.6	45	5	50	14.3	1.6	15.9	15	0	15	5.8	0.0	5.8
New Jersey .	187	30	217	14.8	2.4	17.2	189	27	216	13.5	1.9	15.4	121	15	136	9.0	1.1	10.1	80	9	89	6.2	0.7	6.9
New York...	867	171	1,038	11.7	2.3	14.0	868	169	1,037	11.4	2.2	13.6	820	126	946	11.4	1.8	13.2	758	133	891	10.7	1.9	12.6
Ohio.....	447	66	513	14.3	2.1	16.4	349	32	381	11.7	1.1	12.8	335	30	365	11.7	1.1	12.8	369	29	398	13.0	1.0	14.0
Pennsylvania	196	25	221	11.0	1.4	12.4	195	21	216	11.4	1.2	12.6	178	15	193	11.4	1.0	12.4	132	17	149	8.8	1.1	9.9
Rhode Island	75	11	86	19.0	2.8	21.8	76	13	89	20.7	3.5	24.2	57	8	65	16.6	2.3	18.9	52	8	60	15.8	2.4	18.2
S. Carolina..	35	0	35	5.3	0.0	5.3	37	1	38	6.1	0.2	6.3	35	11	46	5.4	1.7	7.1	50	8	58	6.8	1.1	7.9
S. Dakota...	16	1	17	7.2	0.5	7.7	17	1	18	7.3	0.4	7.7	20	0	20	10.1	0.0	10.1	25	1	26	13.0	0.5	13.5
Vermont....	16	3	19	10.6	2.0	12.6	15	3	18	9.6	1.9	11.5	30	1	31	20.5	0.7	21.2	18	2	20	12.9	1.4	14.3
Wyoming ...	10	2	12	18.2	3.7	21.9	12	4	16	24.5	8.2	32.7	10	1	11	17.0	1.7	18.7	9	1	10	14.3	1.6	15.9
Total.....	2,774	452	3,226	12.2	2.0	14.2	2,720	433	3,153	11.9	1.9	13.8	2,647	357	3,004	11.9	1.6	13.5	2,379	322	2,701	11.3	1.5	12.8

ing factor to certain other mental diseases. On the other hand, it is often a result, rather than a cause, of the disorder, while in many cases it is apparently nothing more than an accompanying condition, no cause-and-effect relationship being discernible. The extent of the prevalence of the intemperate use of alcohol among patients suffering from other forms of mental disease may be seen from an examination of the following summary derived from the data secured by the Federal Census Bureau for all state and private institutions for the year 1922. In this summary are given the total number of new admissions and the number and per cent of intemperate users of alcohol in each clinical group.

Psychoses	*Total number of new admissions*	*Intemperate users of alcohol*	
		Number	Per cent
Traumatic	229	28	12.2
Senile	6,845	378	5.5
With cerebral arteriosclerosis	3,438	351	10.2
General paralysis	6,294	1,049	16.7
With cerebral syphilis	893	123	13.8
With Huntington's chorea	97	6	6.2
With brain tumor	61	2	3.3
With other brain or nervous disease	643	61	9.5
Alcoholic	2,693	2,693	100.0
Due to drugs or other exogenous toxins	615	181	29.4
With pellagra	420	8	1.9
With other somatic diseases	1,806	93	52.0
Manic-depressive	11,393	544	4.8
Involution melancholia	1,803	56	3.1
Dementia praecox (schizophrenia)	15,526	932	6.0
Paranoia or paranoid conditions	1,881	128	6.8
Epileptic	1,813	114	6.3
Psychoneuroses and neuroses	2,777	110	4.0
With psychopathic personality	914	127	14.0
With mental deficiency	1,899	111	5.9
Undiagnosed	4,194	354	8.4
Without psychosis	5,157	1,640	31.8
Unknown	285	30	10.5
All clinical groups	71,676	9,119	12.7

Although the intemperate use of alcohol is here reported merely as an accompanying, rather than as an etiological factor, the high percentages occurring in certain of the

clinical groups are felt to be significant. In this connection the statement of Kraepelin[1] that alcohol was the direct cause of about one-third of all mental affections observed at Munich is of interest, as are also the percentages given by him. He states that "between November, 1904, and November, 1905, nearly one-half of the admissions to the Psychiatric Clinic at Munich were credited to alcohol; of the imbeciles, 42.9 per cent; of the epileptics, 65.1 per cent among the males, and 28.5 per cent among the females; of the manic-depressive cases, 43.5 per cent of the males; of traumatic psychoses, 23.1 per cent; in arteriosclerosis, 64 per cent of the male cases; and of the general paralytics, 51.9 per cent in men and 43.5 per cent in women". He further stated that "one-third of the cases of general paralysis, which is a syphilitic disease, could be avoided by eliminating alcohol".

Comparison of Rates.—Inasmuch as the rate per 100,000 of general population furnishes a very good index to the prevalence of mental disease in general, of the alcoholic psychoses, and of the intemperate use of alcohol among all new admissions, it is of interest to compare these rates. The fifteen states from which data were received on the intemperate use of alcohol for the years 1921, 1922, 1925, and 1926 also provide data showing the total number of male and female cases of alcoholic insanity and similar figures for all new admissions. On the basis of the estimated male, female, and total population for this group of states for each of these years, the rates per 100,000 of general population may be summarized as follows:

RATES PER 100,000 OF POPULATION IN 15 STATES

	1921			*1922*			*1925*			*1926*		
	M	F	T	M	F	T	M	F	T	M	F	T
All new admissions..	53.4	44.2	48.9	56.5	44.6	50.7	53.7	44.0	48.9	52.8	43.0	48.0
Alcoholic psychoses..	2.8	0.4	1.6	3.4	0.4	2.0	4.3	0.7	2.5	4.4	0.8	2.6
Intemperate users of alcohol	10.8	1.5	6.2	11.8	1.7	6.8	11.4	1.9	6.8	11.5	1.9	6.8

[1] *Die Alcoholism in München*, by E. Kraepelin. München Med. Wchn. 1906, Z. iii, 737, cited by George W. Hall, M.D. in "Alcohol in Mental Disease." *Papers from the Conference on Mental Hygiene*, published by Illinois Society for Mental Hygiene, 1923.

TABLE 7. PERCENTAGE DISTRIBUTION BY AGE OF NEW CASES OF ALCOHOLIC INSANITY COMPARED WITH ALL NEW CASES ADMITTED TO STATE HOSPITALS FOR MENTAL DISEASE IN 19 STATES DURING 1926, 1925, AND 1922.

AGE	1926						1925						1922					
	All new cases			*New cases of alcoholic insanity*			*All new cases*			*New cases of alcoholic insanity*			*All new cases*			*New cases of alcoholic insanity*		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Under 15 years	0.5	0.5	0.5	0.1	0.0	0.1	0.6	0.5	0.6	0.0	0.0	0.0	0.9	0.9	0.9	0.0	0.0	0.0
15 to 19 years	4.5	4.1	4.3	0.2	0.5	0.2	4.6	4.5	4.6	0.0	0.5	0.1	4.0	5.5	4.6	0.1	0.8	0.2
20 to 24 years	8.4	7.6	8.1	1.9	2.4	2.0	9.0	7.9	8.5	1.9	1.1	1.8	10.5	9.0	9.9	1.8	0.8	1.
25 to 29 years	10.0	9.4	9.7	4.7	4.9	4.7	9.5	9.7	9.6	4.8	6.5	5.0	12.6	11.5	12.2	5.5	4.0	5.
30 to 34 years	10.2	10.7	10.4	11.1	11.7	11.2	10.7	10.2	10.4	11.1	13.5	11.4	11.3	12.6	11.8	11.1	9.7	11.0
35 to 39 years	11.1	11.3	11.2	17.1	18.0	17.2	12.2	11.8	12.0	17.8	16.8	17.7	11.0	11.5	11.2	18.1	18.6	18.1
40 to 44 years	10.4	9.7	10.1	18.2	15.0	17.8	10.4	9.9	10.2	19.9	18.9	19.8	9.3	11.8	10.3	17.6	21.8	18.0
45 to 49 years	8.9	9.6	9.2	15.0	17.5	15.3	9.1	9.6	9.3	15.9	15.1	15.7	8.3	9.5	8.8	14.9	24.2	15.9
50 to 54 years	7.4	7.6	7.5	11.7	11.2	11.6	7.3	7.7	7.5	13.3	10.8	13.0	6.6	7.1	6.8	13.9	8.9	13.4
55 to 59 years	6.2	5.8	6.0	8.5	8.7	8.6	5.7	5.8	5.7	7.6	8.1	7.7	4.9	4.7	4.8	7.8	4.0	7.4
60 to 64 years	5.7	5.5	5.6	6.4	4.4	6.1	5.5	5.4	5.5	4.6	4.9	4.6	5.2	3.5	4.5	5.3	4.0	5.1
65 to 69 years	5.5	5.1	5.3	3.7	2.9	3.6	5.1	4.8	4.9	1.7	2.2	1.8	4.9	3.0	4.1	2.6	2.4	2.6
70 years and over	10.6	12.5	11.5	0.7	1.9	0.9	9.5	11.3	10.3	0.8	1.1	0.8	9.9	8.4	9.3	0.8	0.8	0.8
Unascertained	0.6	0.6	0.6	0.7	0.9	0.7	0.8	0.9	0.9	0.6	0.5	0.6	0.6	1.0	0.8	0.5	0.0	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Very slight changes have taken place in the rates in these years.

Characteristics of Alcoholic Cases.—In addition to the general information presented above, the 19 states from which complete data were received for the years 1922, 1925, and 1926 returned schedules containing detailed information concerning age, education, environment, economic condition, and marital condition of all new admissions.[1]

Age Distribution.—The percentage distribution by age and sex for all new admissions and for new alcoholic cases is given in Table 7 (page 608). An examination of this distribution not only furnishes a comparison between the percentages of alcoholic and all other cases entering the hospitals at the ages given, but also further confirms the statement made by Pollock and Furbush in the study already referred to that "alcoholic insanity is principally a disorder of advanced middle life". It will be seen that out of every 100 patients with alcoholic psychoses, 76 entered between the ages of thirty and fifty-five in 1922, 78 in 1925, and 73 in 1926—that is, approximately three-fourths of the total number. Of all new admissions, only 49 entered between these ages in each of the years 1922 and 1925, and only 48 in 1926, or a little less than one-half of all new cases. This difference in age distribution is very clearly shown in Chart 4 (page 611), which, because of the large number of cases included and the general similarity of the curves for the three years, may be assumed to be indicative of the typical distribution.

Education.—Of each 100 patients with alcoholic mental disease admitted during the years 1922, 1925, and 1926, respectively, 9, 7, and 8 were illiterate; 22, 17, and 13 could read and write, but had not completed the fourth grade of common school; 56, 61, and 63 had received a common-school education; 6, 7, and 6 had completed high school; and 3, 2, and 2 had finished college. The education of 4, 6, and 7 was unascertained. The percentages by sexes are given in the following summary:

[1] Data for 1922 on education, environment, economic condition, and marital condition are from the study by Pollock and Furbush, above mentioned.

Degree of education	1922		1925		1926	
	Males	Females	Males	Females	Males	Females
Illiterate	9.1	12.2	7.4	3.8	7.5	9.2
Reads and writes	21.5	22.1	16.3	21.4	13.2	13.6
Common school	56.9	50.4	60.7	61.0	63.5	61.7
High school	6.2	6.1	6.5	6.6	6.0	6.3
College	2.9	1.5	2.5	1.7	2.6	0.5
Unascertained	3.4	7.6	6.6	5.5	7.2	8.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

It may be noted that the degree of illiteracy among alcoholic patients is somewhat higher, except in the case of the females in 1925, than the percentages for the entire United States as given in the report of the Federal Census Bureau for 1920. These percentages were: males, 6.0; females, 5.9; and total population, 5.9.

Environment.—For the group of hospitals studied, it was found that of the alcoholic cases 80 per cent in 1922, 84 per cent in 1925, and 82 per cent in 1926 came from an urban environment—that is, from places having a population of 2,500 or over; and that 18 per cent in 1922, 14 per cent in 1925, and 15 per cent in 1926 were from a rural environment. The environment of 2.2 and 3 per cent in the respective years was unascertained. The following summary gives the percentages distribution for environment by sex:

Environment	1922		1925		1926	
	Males	Females	Males	Females	Males	Females
Urban	78.9	93.8	83.0	90.6	80.6	92.2
Rural	19.2	4.6	14.6	7.7	16.0	7.8
Unascertained	1.9	1.6	2.4	1.7	3.4	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

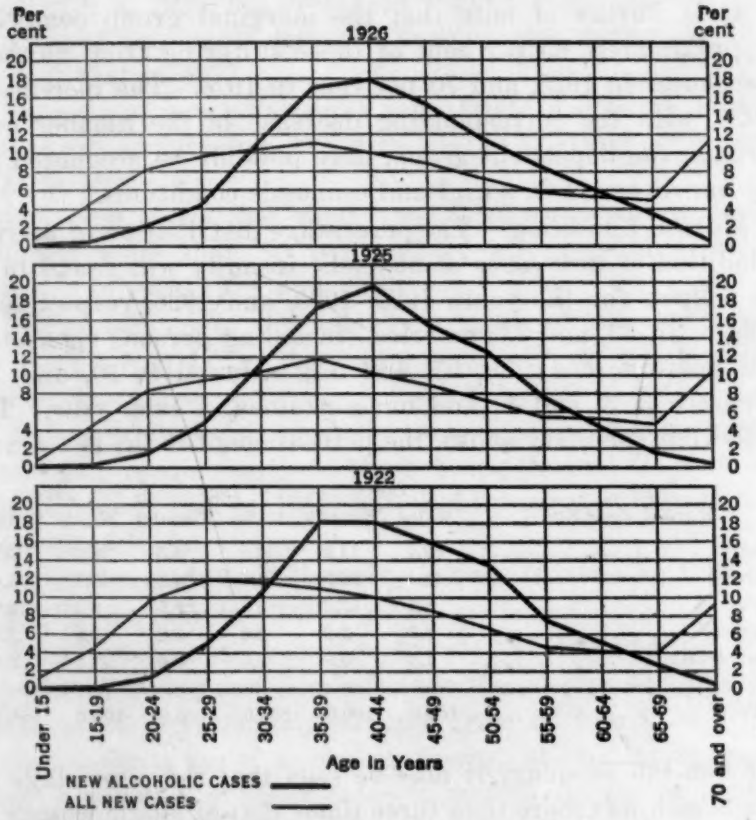
These figures again confirm the statement that a very high percentage of cases of alcoholic insanity come from an urban rather than a rural environment. This is particularly noteworthy in view of the fact that the United States Census Bureau gives the following percentages for urban and rural population in 1920: urban, 51.4; rural, 48.6.

Economic Condition.—The term "economic condition", as used in the reports of the various hospitals, refers to the patients' circumstances before the onset of the psychosis.

All patients are classified as follows: dependent—lacking in the necessities of life or receiving aid from public funds or persons outside the immediate family; marginal—living on daily earnings, but accumulating little or nothing, being on the margin between self-support and dependency; comfortable—having accumulated resources sufficient to maintain self and family for at least four months.

CHART 4

PERCENTAGE DISTRIBUTION OF NEW CASES OF ALCOHOLIC MENTAL DISEASE AND OF ALL NEW CASES ADMITTED TO THE HOSPITALS OF 19 STATES DURING 1922, 1925, AND 1926



For the year 1922, it was found that of each 100 new alcoholic admissions to 94 state hospitals, "21 were reported as dependent, 62 as marginal, and 13 as comfortable, while the economic condition of 4 was not determined". For 81 hospitals reporting in 1925 and 1926, the figures were:

dependent, 20 and 16; marginal, 65 and 69; comfortable, 11 each year; and the economic condition of 4 each year was unascertained. The percentages by sex for 1925 and 1926 are as follows:

Economic condition	*1925*		*1926*	
	Males	Females	Males	Females
Dependent	19.4	20.9	16.4	12.6
Marginal	64.5	67.0	67.6	76.2
Comfortable	10.9	10.4	11.0	10.7
Unascertained	5.2	1.7	5.0	0.5
Total	100.0	100.0	100.0	100.0

It is worthy of note that the marginal group comprises approximately 65 per cent of those suffering from alcoholic psychoses in 1925, and 70 per cent in 1926. The increase in 1926, with the corresponding decrease in the number comprising the dependent group, may possibly be accounted for by improvement in social and economic conditions.

Marital Condition.—The percentage distribution of marital condition of new cases of alcoholic insanity was found to be as follows for the years 1922, 1925, and 1926, respectively: single, 37, 33, and 33; married (including persons separated, but not divorced), 50, 53, and 53; widowed 9, 10, and 10; divorced 3, 3, and 4; and unascertained, 1 each year. The following summary shows the percentages for the two sexes:

Marital condition	*1922*		*1925*		*1926*	
	Males	Females	Males	Females	Males	Females
Single	39.7	11.3	36.0	8.3	36.7	9.2
Married	48.3	66.9	51.5	64.8	49.7	71.4
Widowed	8.1	17.7	8.3	22.5	9.1	12.1
Divorced	2.5	3.2	2.8	3.8	3.0	7.3
Unascertained	1.4	0.8	1.4	0.6	1.5	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

From the summary it may be seen that the percentage of single men was more than three times that of single women in 1922 and approximately four times the percentage of single women in 1925 and 1926. The percentage of married women was considerably greater than that of married men each year, while the women also exceeded the men in the widowed and divorced groups. The excess of married over single

women was much greater than that of married over single men, there being six times as many married as single women in 1922 and approximately eight times as many in 1925 and 1926.

CONCLUSIONS

The data presented above warrant the following conclusions concerning alcoholic mental disease among the new admissions to the state hospitals for mental disease included in the group studied:

The number of new admissions to these hospitals increased from 1922 to 1925, but decreased slightly from 1925 to 1926. In spite of this latter decrease, however, the number in 1926 exceeds that in 1922.

The rate of new admissions per 100,000 of general population shows a slight decrease from 1922 to 1925 and again from 1925 to 1926.

The nine states that were "wet" before prohibition contributed more than 90 per cent of all cases of alcoholic insanity in 1922, 1925, and 1926.

The percentage of alcoholic cases among all new admissions to these hospitals for the years 1922, 1925, and 1926 shows a steady increase.

The percentage of alcoholic cases among all new admissions and readmissions to these hospitals in 1926 was less than one-half that of 1910, but slightly greater than that of 1922 or of 1925.

The rate of alcoholic insanity in twelve states in 1926 was slightly less than in 1919 or 1925.

Both the number and the per cent of intemperate users of alcohol among new admissions to the hospitals of 15 states show a small, but steady increase from 1921 to 1926.

Intemperate use of alcohol is present, at least as an accompanying factor, in many cases of mental disease comprising clinical groups other than the alcoholic psychoses.

The rate per 100,000 of general population in 15 states remained practically constant for new admissions and for intemperate users of alcohol, but increased slightly for alcoholic psychoses, during the years 1921, 1922, 1925, and 1926.

The following characteristics are noted among the cases of alcoholic insanity in the hospitals of 19 states:

Alcoholic insanity is primarily a disorder of advanced middle age, approximately 75 per cent of the cases entering between the ages of thirty and fifty-five years.

The degree of illiteracy abong alcoholic patients is somewhat higher than among the general population of the entire United States.

More than 80 per cent of alcoholic cases come from an urban, in contrast to a rural, environment.

Over 60 per cent of alcoholic cases have been in marginal circumstances, previous to commitment, and approximately 25 per cent have been in dependent circumstances.

With respect to marital condition, more than one-half of the patients suffering from alcoholic mental disease are married and more than one-third single. The number of single males greatly exceeds the single females, while the number of married and widowed females exceeds the number of males so classified.

"WOMAN, WHAT HAVE I TO DO WITH THEE?"

IF Mary, in those months before Christ's birth that shine
So tender, so sublime,
Across scarred, somber centuries,
Had planned with sweet insistence, saying, "These
Things he must surely do, my little son;
Always like this and this our race has won
Nobility",
Would he,
The child, have grown
To greater stature than his race had known?

But long before the first faint flutter stirred
Within her, Mary heard,
Authoritative, beautiful, a word;
Perhaps the wisdom of her spirit spoke,
A word that told
Her that the child that she would hold
Against her breast was royal. In deference Mary pressed
No brand of her designing on her son; she guessed
His purpose would fulfill itself and be
Clear to him as he strengthened for it; she
Let him, a youth, depart
From her, aloof, and in her heart,
Bereft and glad, pondered anew his saying . . . so alone
He sought and found—a throne.

JULIA WELD HUNTINGTON.

Norwich, Connecticut.

ABSTRACTS

THE VOLUNTARY HEALTH AGENCY. By Barry C. Smith. *American Medical Association Bulletin,* 24:144–49, May, 1929.

Harmonious coöperation between the voluntary health agency, the official health agency, and the private physician in carrying out a public-health program depends primarily upon mutual understanding and consideration. In its relations with the private physician, the voluntary health agency should recognize two facts: (1) that the physician is still largely occupied with the curative rather than the preventive and constructive aspects of medicine; and (2) that while he concedes the necessity of health agencies to handle such community problems as water supply, sewage disposal, and the like, he is still inclined to regard treatment of the individual as his particular province and to resent encroachment upon it. This attitude is likely to cause ill feeling in connection with such questions as immunization and the establishment of health centers for children—measures that involve treatment of the individual and yet are not the type of service that the individual is in the habit of seeking from his physician. In such matters the function of the voluntary health agency should be largely educative. It should educate the public to the necessity of the service, but should make it a practice to refer individuals to their own physicians for treatment, unless the physicians themselves decide that the service had better be performed by a health agency, voluntary or official. At the same time the physicians should be educated to make an active effort to develop their practice along preventive and constructive lines, as dentists are already doing.

In relation to the official health agency the function of the voluntary agency should be, briefly, to supplement, to educate, to demonstrate, to give moral and financial support, and at the psychological moment to disappear.

PSYCHOLOGICAL OBJECTIVES IN PHYSICAL EDUCATION. By J. R. Young. *American Physical Education Review,* 34:92–95, February, 1929.

This author points out some of the opportunities in physical education that he feels are being neglected at present because of a lack of coöperation between the departments of physical education and the academic departments in high schools and colleges, a situation in his opinion largely due to the persistence of a medieval concep-

tion of mind and body as two separate entities, of which the mind is by far the higher and more important. Influenced by this conception, the academic instructor is inclined to feel himself upon a higher plane than the teacher of physical training, with the result that a sharp line of demarcation is almost universally drawn between the two types of instruction and a certain antagonism has arisen between their respective exponents. This is unfortunate, since each needs what the other has to give.

The academic educator would do well to remember the value of games and sports as forms of intellectual, emotional, and volitional training. Rightly used, they are excellent agencies for developing initiative, resourcefulness, and independence and for building up that fine coördination between the nervous system and the muscles that leads to grace and ease and poise, qualities that are of economic and social as well as æsthetic value.

An important objective of physical education is the inculcation of ideals of health, physical efficiency, and emotional control. Emotional disorders are on the increase and it is significant that neuropathic individuals are usually introverts who have spent little time in athletics and sports. Activities of this kind are invaluable in preventing the development of high nervous tension. They are a natural safety valve for the emotions. And if, in developing the muscles of the body, constant emphasis is placed upon moral stamina, persistence in playing the game through, and endurance of hardship, the result will be a stiffening of the moral fiber of the youth which is, in the judgment of the author, one of the most important contributions of physical education. Competitive sports are also a splendid training in fair play, in coöperation, in the ability to maintain emotional balance in a crisis, in modesty in victory and self-control in defeat—in short, all the qualities that enter into the code of the "good sport". This code should be unremittingly emphasized throughout the whole course of physical education.

The attitude prevalent in our educational institutions to-day that the primary aim of organized athletics is to advertise the school or college has, in Mr. Young's judgment, had most unfortunate results. It places an exaggerated emphasis upon winning, which not only menaces good sportsmanship, but has led to such evils as the subsidizing of individuals of high athletic, but low intellectual, capacity. It tends also toward overspecialization, which results inevitably in a rather one-sided physical development.

The educator should look upon games and athletics as a wholesome and natural means of satisfying some of the strongest impulses of man's nature. First and foremost, they should serve as an out-

let to the play instinct or impulse. Under our present system of physical education, there is danger that this primary function of sports may be disregarded. In some cases they are undoubtedly regarded as a hard grind, to be undertaken, not for the joy of the activity, but for the rewards to be derived from it.

Another instinct for which sports offer a legitimate means of expression is that of self-display. This instinct is at its height in adolescence and should be provided for in any scheme of physical education. Opportunities for the display of athletic prowess, such as field days and other athletic events, and recognition of special attainment or successful accomplishment by such symbols as the letter on the sweater or the trophy cup, are invaluable for this purpose, always provided that they are not allowed to become the primary objective of the athletic program.

Pugnacity is a third deeply rooted instinct that finds a normal, healthy outlet in games and athletics, and that they can help to develop into a constructive element in the personality.

Workers in the field of physical education have long recognized the value of corrective gymnastic exercises for the body, but they have not been equally alert to the opportunities offered by games and sports for the correction of minor psychic abnormalities. Three types are mentioned as illustrations. There is, first, the over-modest, retiring individual of indifferent physique who suffers from a more or less definitely established inferiority complex. "Because of their general weakness and sense of inferiority, it is impossible to make athletes of more than a very few of them. They should, however, be encouraged to practice unremittingly some one game which is in fairly high prestige among adolescents. If they can be brought to the point where their proficiency surpasses the average for their group, this accomplishment becomes a tremendous asset in building up their morale and increasing their self-respect."

A second type is the very aggressive, egotistical individual who wants to play the game himself and will take long chances for the sake of greater personal glory. He must be taught to play as a member of the team and be taken out of the game every time he fails to do so, even though his removal may mean the loss of the game, and he should frequently be pitted against players who are better than he.

The third type for which the physical-education department can do a great deal is the dullard. Only too often the dullard gets little out of his academic work except the sense of failure. "If such individuals could be led to the attainment of excellence in some line of sport, it might be possible to bring many of them through

their limited school course with their self-respect still intact. Under present conditions many of this group find their school work a positive detriment. It robs them of two priceless heritages—self-respect and ambition."

ECONOMIC LOSS ON ACCOUNT OF HOSPITAL CASES OF MENTAL DISEASE AND ASSOCIATED PHYSICAL DISORDERS IN NEW YORK STATE, 1928. By Horatio M. Pollock. *The Psychiatric Quarterly*, 3:186–95, April, 1929.

The economic loss due to hospital cases of mental diseases is made up of two main items: (1) the cost of maintaining the patients in hospitals and (2) the loss of the patients' earnings. The first can be subdivided into (A) the cost of hospital care and treatment, including medical and nursing service, food, clothing, upkeep of buildings and grounds, and so forth; (B) the investment charge—that is, interest on the value of hospital plant and equipment and allowance for depreciation; and (C) the cost of general administration, which includes not only the administrative expenses of the department of mental disease, but the cost of the services performed for the department by other state departments and state officers.

For the fiscal year ending June 30, 1928, the per capita cost of care and treatment in the civil state hospitals of New York was $404.82 and in the hospitals for criminal insane $464.54. For the licensed institutions, Dr. Pollock estimates it at $2,000.

In computing the annual investment charge, he uses as a basis the cost of the new units at Kings Park, Creedmoor, and Rockland State Hospitals. These are the best figures available, since the last general appraisal of the land and buildings of the civil state hospitals was made as of January, 1912, when real-estate values were much lower than at present, and no new state hospital has been built and equipped in recent years. Computing from the cost of the new units, he places the present average outlay for plant and equipment at approximately $4,000 per patient for the state hospitals and $6,000 for the licensed hospitals. Using 5 per cent as a fair rate of interest and adding 2 per cent for depreciation, he estimates that the annual investment charge amounts to $280 per capita in the state hospitals and $420 in the licensed institutions.

The expenditures of the administrative offices of the department of mental disease in 1928 came to $6.71 per capita. The expenditures of other state departments and agencies for services to the state hospitals would probably increase this to $10 per capita.

On the basis of these figures, the maintenance cost of the 43,639 patients in the civil state hospitals in 1928 amounted to $30,358,909;

of the 1,719 patients in the hospitals for criminal insane, to $1,297,056; and of the 2,640 in licensed institutions, to $6,415,200—a total of $38,071,165.

In computing the loss of earnings due to the disability and premature death of patients with mental disease, Dr. Pollock uses the figures of Drs. Dublin and Lotka, of the Metropolitan Life Insurance Company, on the net economic value of a typical male wage earner at various ages. The economic value of the average woman is assumed to be half that of a man.

The proportion of this economic value that is lost when an individual develops mental disease and is admitted to a hospital, Dr. Pollock estimates separately for each clinical group, after a careful consideration of discharges, deaths, and duration of hospital life in each group. Thus, in cases of general paralysis, he estimates it at 75 per cent; in senile cases, at 95; in alcoholic cases, at 50; in the dementia-praecox group, at 75; and so forth.

To obtain the figures for 1928, he classifies according to sex and psychosis the first admissions to the state hospitals and the committed first admissions to the licensed institutions during that year, and determines by the Dublin-Lotka table what economic value each clinical group would represent if the individuals in it were normal. Multiplying this sum by the estimated percentage of loss due to the psychosis in question, he gets the amount of the loss for each group. The sum of the losses in the various groups comes to $67,542,629 for the males and to $24,364,841 for the females. To these losses must be added those of the voluntary and physician-certificate patients admitted to licensed institutions during 1928. As ages and psychoses are not reported in such cases, Dr. Pollock computes the losses of this group from the figures for the committed group, estimating them at $10,178,850 for the males and $3,444,768 for the females. This brings the total loss of future earnings of first admissions to $105,531,088, which, added to the $38,071,165 spent for maintenance, gives a grand total of $143,602,253 as the loss due to hospital cases of mental disease in New York State in 1928.

Of interest also are the figures for the losses due to some of the individual psychoses. Thus, the loss on account of general paralysis is estimated at $15,757,008, and on account of syphilis at $813,588, making a total of $16,570,596 for the syphilitic group. Cases of alcoholism are responsible for a loss of $6,561,973, while the loss from dementia praecox amounts to the enormous sum of $61,907,331.

BOOK REVIEWS

COMING OF AGE IN SAMOA; A PSYCHOLOGICAL STUDY OF PRIMITIVE YOUTH FOR WESTERN CIVILIZATION. By Margaret Mead. New York: William Morrow and Company, 1928. 297 p.

This book was given to me by an old rake in evident disappointment over the fact that it had not turned out to be a salacious novel, as he had been led to believe from the lurid paper cover. This cover portrays a Samoan youth chasing a girl in a grass skirt "under the palm trees". One does not have to read very far to learn that "under the palm trees" is the accepted rendezvous for clandestine lovers. In addition, there appears in red print George A. Dorsey's comment: "I wonder if we shall ever be as sensible about sex as the Samoans are." Whether or not these are designs aimed at increasing popular consumption, the book is a valuable sociological contribution. It is the kind of source material upon which such monumental works as Briffault's *The Mothers* are built. No doubt its sensational get-up is the publisher's, rather than the author's, method of increasing popular sales of the volume.

The data upon which the book is based were gathered by the author during a period of residence among the Samoan natives—first-hand information, therefore, of the most authentic kind. She set out with an express purpose in view. Aware of the storm and stress of the adolescent period in America, Miss Mead wondered whether the symptoms of unrest during this period are inevitable concomitants of the physiological changes or whether they are due to the environment with which the adolescent is confronted and in which he matures. Are "these difficulties due to being adolescent or to being adolescent in America"? It is obviously impossible to apply the behaviorist's experimental method of controlling the variables. Miss Mead, therefore, turned to the anthropological method, really a comparative sociological study, and sought a civilization in which the environment is radically different. Especially are the attitudes toward sex in that society fundamentally different from our own; and since much of adolescent unrest is centered about sex, it would seem that a comparison of the influence of these differing attitudes upon the adolescent is particularly illuminating and valid. Miss Mead finds a complete absence in the Samoan girl passing through puberty and adolescence of any of the signs and symptoms of stress and maladjustment that one frequently encounters in American youth. "Adolescence represented no period of crisis or stress, but was instead an orderly

development of a set of slowly maturing interests and activities. The girls' minds were perplexed by no conflicts, troubled by no philosophical queries, beset by no remote ambitions. To live as a girl with many lovers as long as possible and then to marry in one's own village, near one's own relatives, and to have many children, these were uniform and satisfying ambitions."

The Samoan child is from the earliest years exposed to sex knowledge; she witnesses intercourse, abortions, and births. Sex thus loses its mystery, gives rise to no guilty knowledge, and is relegated to the category of physiological functions; the chief restrictive impositions are those of ordinary decency—*e.g.,* one would not defecate or engage in sexual intercourse in the public square — plus, of course, the taboo relating to one's own family. Furthermore, the boy, on reaching puberty, is taught all the details of sex and the art of love-making. "The fact that educating one sex in detail and merely fortifying the other sex with enough knowledge and familiarity with sex to prevent shock produces normal sex adjustments is due to the free experimentation which is permitted and the rarity with which both lovers are amateurs." "Familiarity with sex, and the recognition of a need of a technique to deal with sex as an art, have produced a scheme of personal relations in which there are no neurotic pictures, no frigidity, no impotence, except as the temporary result of severe illness, and the capacity for intercourse only once in a night is counted as senility." "Marriage, on the other hand, is regarded as a social and economic arrangement in which relative wealth, rank, and skill of husband and wife, all must be taken into consideration. There are many marriages in which both individuals, especially if they are over thirty, are completely faithful. But this must be attributed to the ease of sexual adjustment on the one hand, and to the ascendency of other interests, social organization for the men, children for the women, over sex interests, rather than to a passionate fixation upon the partner in marriage. As the Samoans lack the inhibitions and the intricate specialization of sex feeling which make marriage of convenience unsatisfactory, it is possible to bulwark marital happiness with other props than temporary passionate devotion. Suitability and expediency become the deciding factors."

But there are other differences in attitudes and customs between Samoan society and our own that have their effect upon adolescence and play as great, if not a greater, rôle in effecting an easy adolescent adjustment in Samoa. There is the general casualness and lack of deep feeling with which the Samoans face all the problems of life. "For Samoa is a place where no one plays for very high stakes, no one pays very heavy prices, no one suffers for his convictions, or

fights to the death for special ends. Disagreements between parent and child are settled by the child's moving across the street, between a man and his village by the man's removal to the next village, between a husband and his wife's seducer by a few fine mats." Of special interest to the behaviorist, the psychoanalyst, and the child-guidance worker is the difference in social and psychological environment of the first few years—family relationships and conflicts. "The organization of a Samoan household eliminates at one stroke many of the special situations which are believed to be productive of undesirable emotional sets. The youngest, the oldest, and the only child hardly ever occur because of the large number of children in a household, all of whom receive the same treatment. Few children are weighted down with responsibility or rendered domineering and overbearing as eldest children so often are, or isolated and condemned to the society of adults and robbed of the socializing effect of contact with other children, as only children so often are. No child is petted and spoiled until its view of its own deserts is hopelessly distorted, as is so often the fate of the youngest child." "The close relationship between parent and child, that submission to the parent or defiance of the parent which may become the dominating pattern of a lifetime, is not found in Samoa." The diffusion of feeling and affection possible in the loosely organized Samoan family is in striking contrast to the specialization and fixation of emotion in our own small, ingrown biological family. There is lacking the tendency to base conduct on affection ("Please be good to mother" and "Go to church for father's sake") rather than on a broader tribal ethics.

Still other differences in social structure and social attitudes that have their influence on the pre-adolescent are the presence of many strongly held and contradictory points of view and the enormous influence of individuals in the lives of our children; the Samoans' low level of appreciation of personality differences and poverty of conception of personal relations; their "general educational concept, which disapproves of precocity and coddles the slow, the laggard, the inept"; their scheme of introducing very early into the life of the child definite tasks graded to their strength and intelligence, but having a meaning in the structure of the whole society, their child's play having no relationship to adult work, as in our own scheme; the matter of choices, the Samoan adolescent not being faced by the number of nor the pressure to make, important choices, such as those involved in religion, morality, a career, political preferences, and what not.

Miss Mead wisely refrains from giving rash solutions of our

adolescent problems on the basis of these comparisons and contrasts. "Many points are useful only in throwing a spotlight upon our own solutions, while in others it is possible to find suggestions for change. . . . Our attitude towards our own solutions must be greatly broadened and deepened by a consideration of the way in which other peoples have met the same problems."

In the final chapter, *Education for Choice,* the author realizes that adolescence is not necessarily a time of stress and strain, but that cultural conditions make it so; that these conditions are the flesh and bone of our society and no more subject to straightforward manipulation than is the language we speak. Some slight change in our attitude toward sex might be possible, *e.g.,* the sex conduct of young people might be conceived of as experimentation instead of as rebellion; "but when there is added to the pitfalls of experiment the suspicion that the experiment is wrong and the need for secrecy, lying, and fear, the strain is so great that frequent downfall is inevitable". It is in the matter of choices that our greatest hope lies. "We must turn all of our educational efforts to training our children for the choices which will confront them. Education, in the home even more than at school, instead of being a special pleading for one régime, a desperate attempt to form one particular habit of mind which will withstand all outside influences, must be a preparation for those very influences. Children must be taught how to think, not what to think. Unhampered by prejudices, unvexed by too early conditioning to any one standard, they must come clear-eyed to the choices which lie before them."

In the appendix the author tabulates her data objectively and gives a brief mental-hygiene survey of the villages in which she worked. This tends to show the relative infrequency of adult neuroses and psychoses.

The book is extremely readable and the style excellent. It is a remarkable study in causation, from which the reader may draw his own conclusions, remembering always that civilization is purchased at a price. This price may be too high in some instances, but that is the inevitable result of that aggressive attack upon the problems of reality which has brought us our civilization and has lifted us above savagery. Thus, the inhibition and postponement of sexual expression has raised sex to a higher plane, has given us the beauty of romantic love, and has turned a vast amount of libidinal energy into ego drive with a resulting superiority of achievement.

ARTHUR R. TIMME.

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CHILDREN'S BEHAVIOR AND TEACHERS' ATTITUDES. By E. K. Wickman. New York: The Commonwealth Fund Division of Publications, 1928. 247 p.

It is a maxim known to all adults that "good" children are those who do not bother their elders. Children who refuse to adopt this maxim are known as "problem" children. What psychologists who refuse to adopt it are known as is an interesting field for speculation, but Mr. Wickman has apparently been willing to run the risk. In pursuit of the fascinating possibility that there might be problem teachers as well as problem children, and that there might, indeed, be some co-relation between the two, he has proceeded to an investigation and classification of the forms of pupil behavior which teachers seem to regard as generally and persistently troublesome. Then, having arranged these troublesome acts in the order of frequency with which the teachers complained of them, he submitted the same list of misdeeds to a group of clinical psychologists to be arranged in the order of their importance for the psychological health of the child. He hardly needs to set forth his tabulations to point the inevitable moral.

Grouping the almost endless list of specific misdeeds into general classifications, Mr. Wickman is able to summarize the attitudes of teachers as follows: most important and serious in their eyes are immoralities and dishonesties and transgressions against authority; next in importance and seriousness to these come violations of orderliness in class and lack of application to school work; next to these, in turn, come extravagant, aggressive personality and behavior traits; and last and least important are the withdrawing, recessive personality and behavior traits. More obvious evidence of the widespread persistence of the maxim mentioned in the preceding paragraph it would be difficult to find. Indeed so completely do these findings mirror the attitudes, not only of teachers, but, as Mr. Wickman points out, of parents and adults generally as well, that further comment is almost superfluous.

The psychologists have a different story to tell. For them the most serious and important forms of "misbehavior" are these same withdrawing, recessive personality traits which bothered the teachers least. Next to these in importance come dishonesties, cruelty, temper tantrums, and truancy. Next to these, in turn, are the immoralities, violations of school requirements, and extravagant behavior traits. Last and least important are the teachers' favorite shibboleths, transgressions against authority and violations of orderliness in class.

Mr. Wickman comments briefly on this state of affairs, pointing out that the teachers' attitudes in such cases are in effect defense

mechanisms for the protection of the personality and authority of the adult. When the child breaks a rule, whether in some matter of general moral conduct or in the matter of a specific school requirement, his defiance amounts to an attack on the personality of the adult who promulgates and defends the rule. As a result, the teacher tends to respond, as most human beings do to an attack, by a blind blow (not necessarily literally, of course) in return. The psychologist, less concerned with the preservation of the rule, sees the child's "attack" as less serious, as indeed almost a sign of mental health, while he regards the withdrawing and recessive behavior as possibly the beginning of serious maladjustment for the child.

Mr. Wickman's suggestion is that teachers be more adequately informed concerning what constitutes "normal" behavior and concerning the origins of children's difficulties in adjustment. He points out that many adults have themselves failed to adjust to these same problems and cannot, under such circumstances, be very successful teachers of children. A reëducation in teachers' attitudes would, he thinks, improve the teacher-pupil relationship.

Of the general soundness of all this there can hardly be any question. One point remains that Mr. Wickman has not, perhaps, quite appreciated. Our schools are still conducted, tacitly though not admittedly, on the principle made immortal by Mr. Dooley: "It doesn't matter what you teach a boy, Hennessy, so long as he doesn't like it." Of this situation the teacher is likely to be quite as much a victim as the pupil. Many times when the child and the rules come into conflict, the only solution is a new kind of school, and new kinds of schools do not materialize like rabbits out of a magician's hat. That the teacher should ever find it necessary to sacrifice the pupil to the rule is deplorable beyond all expressing, but some of the responsibility must rest on the administration and on the community. The reëducation in attitudes of which Mr. Wickman speaks is vitally needed, but teachers, as Mr. Wickman would probably readily admit, are not the only ones who need it.

Northwestern University. T. Livingston Scholtz.

Physique and Character: An Investigation of the Nature of Constitution and of the Theory of Temperament. By E. Kretschmer, M.D. Translated from the second revised and enlarged edition by W. J. H. Sprott. New York: Harcourt, Brace, and Company, 1925. 266 p.

There would be little occasion to notice this book in its second edition if it were not to point out the fact that there have been

many additions to the literature in the last few years—studies to which there is scant reference in Kretschmer's book, many of them having been made since he revised his German edition in 1922.

It should be known to those interested in this field that a very competent comparative review of the whole subject of biological types, as expounded by Kretschmer, Spranger, Von Klages, Ewald, and several others, was published in 1926 by H. Hoffman, under the title of *Das Problem Des Charakteraufbaus.* This work deals particularly with the relationship of body type to personality. A still more detailed comparative study of constitutional types, by F. Weidenreich, was published in 1927 under the title *Rasse und Koerperbau.* The findings of the German, French, and Italian schools are here presented in most interesting form from the standpoint of the relation of bodily structure to racial characteristics—certainly a highly important matter. A mere survey of the literature in bibliographic form occupies five large, closely set pages, which give to the student an indication of the extent of the research on the subject of body structure. Still more recently, we are fortunate enough to have the very notable work of Nicola Pende presented to us in the English translation by Naccarati (1928) under the title of *Constitutional Inadequacies; An Introduction to the Study of Abnormal Constitutions.* This fascinating volume, by the famous professor of clinical medicine and director of the Biotypological Institute of Genoa, shows, as no other work does, the many constitutional problems, other than those of anthropometrically determinable structure, that have to do with the better understanding of the nature of man, even from a psychological standpoint.

From all this it is evident that the last word is very far from having been said upon the relationship of body structure and function to personality or to mental abnormality. Kretschmer's studies, to come back to him, must be viewed in the light of Viola's work, which dealt particularly with the "total constitution". Then the whole matter must be considered from the standpoint of the comparative theories of body structure as presented by Weidenreich. Finally, we may well come to the localized body or organic characteristics, the "partial constitutions" that Pende deals with. The whole matter thus becomes tremendously complicated.

Kretschmer gave a great impetus to research in this field through his interesting presentation of the subject. He stood midway between the earlier students of the constitutional types, who evidently had little conception that there was anything very practical to offer in the way of elucidation of personality types, and those who have taken a much more critical view and have seen greater complexities.

But the whole subject remains immensely fascinating, with indications of permanent values for the psychiatrist and the psychologist appearing here and there. It is clear, however, that massive generalizations are not likely to prove of great value.

WILLIAM HEALY.

Judge Baker Foundation, Boston.

CHILDREN IN THE NURSERY SCHOOL. By Harriet M. Johnson. New York: The John Day Company, 1928. 325 p.

Increasing interest in the nursery school makes Miss Johnson's book a very timely one. It is also exceedingly honest; it starts with a frank acceptance of the fact that we are still learning about the pre-school child and that many questions of nursery-school routine are still open to discussion. The following passage is typical of the balanced and objective point of view that pervades Miss Johnson's work:

"Upon the subject of training in bladder control we hold a point of view which is at variance with that of the usual parent or physician and perhaps with many persons who have small children under their charge. I believe that too much emphasis has been laid upon the importance of acquiring early control of urination and other habits of self-help. Parents begin correctly when they attempt to establish regular habits in urination and the evacuation of the bowels when the baby is a few months old. They make no demand upon the baby, but assume the responsibility of placing him in the correct position at regular intervals. By the time he can creep, however, the method is likely to be changed. The child is exhorted to 'tell mother'. Often he is reproved or even punished for involuntary voiding of urine, and from that time on till control is physiologically established, the subject is one of exaggerated importance in the minds of the parents, of much discussion when children are being talked about and above all when mother and child come together. Various attacks are made upon it, a usual one being the effort to create in the child an aversion for soiled clothing and an association of disgust with the sight of urine and feces.

"We have raised the question whether much of the storm and stress experienced in the adolescent and adult years over the problem of sex relationship and an adjustment to sex life are not tied up with an early misunderstanding regarding the processes of elimination and those of sex. However that may be, it is one thing which we have in mind in putting a minimum of emphasis upon the habits concerned with elimination, at the same time endeavoring to get each child's 'rhythm'—*i.e.*, the periods between voiding—so that he can be taken

to the toilet and thus remain dry. We are still raising interrogations as to the importance of even this amount of supervision, that is, if being kept dry has any effect upon the establishment of bladder control." (Pages 29–30.)

This is only one example of Miss Johnson's attitude toward child-training problems in the nursery school, but it illustrates her philosophy. The whole aim of nursery-school training is not to impose conventions and routine decided from without, but to provide a favorable environment for the natural development of the child. "Growth is progress toward maturity. It is, however, a continual and gradual process, complete at each stage, or perhaps I should say capable of functioning at each stage. The duty of the educator is to see that the capacities of each stage are fully realized, not that the stages succeed each other as rapidly as possible." (Page 9.) This point of view carries us somewhat away from the emphasis on habit training which has too often been conceived as the primary function of the nursery school. "We cannot build up an entire educational system upon the cultivation of habits, important as they are . . . the habits which a person acquires are of less significance than the use he makes of them." (Page 17.)

How does this philosophy work out in actual practice? There is recognition of the differences between those things that are essential to the child's health and those that are demanded by adult social standards. There is much time spent upon securing good food and sleep habits, because these are necessary for physical well-being. On the other hand, children under three years of age are not expected to dress and undress themselves without adult assistance; nor is any stress placed upon the cultivation of pretty manners or the use of such expressions as "please" and "thank you", which at the nursery-school age can be only mechanical responses without any real meaning to the child. Even in methods of establishing the very necessary habits of proper eating and sleeping, there is much variety of procedure based on an understanding of individual differences. For instance, adult aid may be supplied to a child whose muscular coördination is not sufficiently well developed to insure successful self-feeding, but denied to a child who is simply trying to prolong the period of infantile dependency.

Thus far we have indicated only the kinds of problem that are discussed in the first two chapters of Miss Johnson's book. The other chapters are equally refreshing and stimulating. They treat of the following subjects: the schedule and the rules; the physical environment; the social environment; language and rhythm; record keeping

in the nursery school. Altogether this may be regarded as an excellent handbook of the best nursery-school technique.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

THE MORAL SELF; AN INTRODUCTION TO THE SCIENCE OF ETHICS. By Charles L. Sherman. New York: Ginn and Company, 1927. 365 p.

In his preface the author outlines his purpose as follows: "The present volume attempts to present the problems of the moral self in as untechnical a manner as possible. Likewise is the attempt made to trace the genesis of the moral self, in terms of its essential features, from biological foundations to metaphysical implications."

In the first chapter he gives a general orientation for the presentation of the subject from his point of view. He outlines, as forms of mental organization, the following: (1) emotional, (2) logical, (3) philosophical, and (4) moral. He holds the mind to be consistent along the lines of these four categories, the first three being but a preliminary to the fourth, "which is the consistency of the moral self". He states that the moral self is "a qualitative attitude which is always turned in the direction of the reciprocal interests of society and of self". He proposes four requisites: (1) ideals, (2) feelings, (3) tendencies, and (4) organization. He believes that it is necessary in early life to have a fairly constant moral environment in order to develop the moral self to its highest possibility. He also discusses types of humanity on the basis of attitude toward the universe, under the headings of the optimist and the pessimist, the introvert and the extrovert. He holds that such extreme views constitute a prejudice which, if adopted in early life, may be sufficient to become the background of a permanent philosophy of life. "It is likely that prejudice is the foundation for most moral natures even of the very highest order—but beyond the early states of one's moral experience it should have no further rôle to play."

Self-observation is considered important for self-evaluation and the author would make self-criticism a criterion of intelligence. But he would not have the individual introspective too early in life. "It is much better to be a normal human being with normal objective interests than to become a psychologist." Sensation, purposes, and associations are advanced as the sources of selfhood, and the higher experiences of ideals and purposes are considered as formative. Throughout this first chapter he dwells a great deal upon unity of the individual. "Unity has been our most important thesis—a moral unity as well as a psychological unity."

In the second chapter he deals with psychological tendencies in relation to the self. He considers three stages in the development of moral activity: (1) the unconscious development of interests and tendencies to action; (2) the conscious and purposeful development of interests and tendencies; (3) the abnormal development of interests and tendencies. "It is possible to summarize three theses in a nutshell: The aim of education is the proper directing of human tendencies; the lack of education is the failure to develop one's tendencies; and the abnormal self, if we may use the term self, results from the misdirecting of human tendencies." The thesis is then advanced that similar mental states tend to succeed one another, and this sequence takes place along three lines—the emotional, the habitual, and the logical. These are considered in special relationship to morals. He holds also that mental processes tend to attain an ideal status, but that this tendency is an acquired one. "When this stage has been reached (and ordinarily it never is reached) the moral self advances by leaps and bounds." Stating that moral values are not competitive and that the moral self is built up by self-sacrifice, he passes to a discussion of art to illustrate his point.

In Chapter III the biological foundations of the moral self are considered. Individual variations in intellectual and moral capacity and the application of these variations in education and industry are discussed at length. A discussion of racial variation follows. The author states: "The idea that nations differ in innate capacities is not at all novel in the history of social thought." (This doctrine of differences in racial capacity is receiving very severe criticism to-day. While it is probable that quantitatively the racial capacities are approximately equal, it is also probable that there are fundamental qualitative differences.) He states further that races differ less in moral integrity than in range of intellect, but that "racial morality is subject to wide variation. Two distinct races may possess equal degrees of moral integrity, but such integrity will manifest itself in a myriad of forms."

Instincts are next discussed as possible roots of the moral self. The author reaches the deduction that "in the fields of education and morals the instincts seem to provide the necessary background for intellectual and moral motivation. This does not imply that instincts are motives in themselves; it means that motives arise from such tendencies." He holds that there is a unity of the physical, the mental, and the moral capacities, all three being more or less interdependent. He discusses next ambivalence of interests and emotions in their relation to regression and the development of anti-social tendencies. The chapter closes with a discussion of habit and its bearing on moral behavior.

Chapter IV opens with a discussion of the forms of self-organization. Five principles are advanced: (1) the mechanical, (2) the logical, (3) the organic, (4) the purposeful, and (5) the self-conscious. Each of these the author discusses in their relation to morals. The mechanized character he believes could never attain a truly moral status, as it simply mirrors the society surrounding it. The logically and the organically synthesized personalities are considered to be early stages of moral synthesis. The purposeful organization of the self holds potentialities for the subordination of minor life interests and the development of a truly virtuous life. The self-conscious organization permits of recognition of one's self as a responsible and free moral agent.

The fifth chapter deals further with psychological concepts. The moral self is analyzed in terms of feeling, cognition, and will. Feeling is analyzed under the headings of feeling, motivation, and sentiment. One is cautioned against the tendency of persistent affect to narrow thought. The author considers that feelings give rise to motives and therefore essentially underlie moral behavior. "A really dynamic and constructive character can be founded only on motives that are fully conscious and definite." He draws a distinction between purpose and motive. The motives and feelings in turn, when properly organized, give rise to sentiments, which he considers to be the funding agencies of the moral self when they are attached to justice, integrity, honor, and so forth. He considers the moral energy arising from the sentiment to be directly proportionate to the normal maturity of the sentiment itself. The moral sentiments are held to give rise to conative tendencies. "The four stages of mental conation are as follows: first, the instinctive and spontaneous stage; secondly, the conscious interest in the attainment of some object or the accomplishment of an ordinary task of life; thirdly, the development of one or more specific virtues, or even the desire to live a virtuous life; fourthly, the desire and satisfaction that supervene upon the unfolding and expansion of the moral self."

Under cognition, he analyzes first environmental factors and their effects early and late in life, psychological determiners, sources of aversion and desires, and sources of minor morals. Moral percepts, concepts, and ideation are then discussed. He considers the concepts the controlling mechanism for the impulses. This brings him to a discussion of the will. "The first function of the will does not consist in the repression of desires and impulses; neither is it wise to allow the impulsive life free reign; but the primary function of the will is the proper guidance of the affective and conative tendencies."

Enough has been given so far to illustrate the general plan of attack. In the next two chapters he considers morals in relation to

society—"socializing the self"—and in relation to social forces and social institutions. In the eighth chapter he discusses the self in relation to moral judgment. Defining the meaning of moral judgment, he states that "any statement or assertion which predicates a moral quality or act is an example of moral judgment". The content of moral judgment would have the following indices: the historical, the social, the educational, and the formal virtues. The first would deal with man's present moral status; the second with the moral status of the community; the third with formal normal education; and the fourth with the abstractions of the formal virtues. The origin of this content he finds in heredity, environment, and the will. As to the sanctions of moral judgment, he quotes Bentham and Spencer.

In Chapter IX specific objects, agents, standards, and values are considered. Chapter X deals with the moral self in its relations to the personality. The stages in the development of moral personality are outlined. "The first stage is that stage in which the personality takes root and buds with the utmost secrecy . . .; the second stage of its growth, which we characterize as the selective choosing, though relatively unstable, is valued in terms of individual choice and social approbation . . . It is only as we pass from adolescence to spiritual maturity that we find real qualitative changes in the chosen personality. The instability of adolescence gradually becomes the stability of adulthood, as cosmic approval takes the place of social approval. Character is no longer fragile and many-sided, but permanent and enduring. Man's moral reserves have been tapped, and human personality, the highest gift of conscious choice, has assumed its rightful heritage."

The reviewer scarcely knows how to evaluate this work. He was seldom in rapport with the author at any stage in the development of the thesis. Moreover, long-continued perusal of scientific articles in which the objective data of actuality are presented prior to the drawing of conclusions spoils for one any work like the present, which contains innumerable assertions unsupported by any factual evidence. The primary thesis that the personality may be integrated on a moral basis is not demonstrated, in my opinion, by this work. To pick out at random a few examples of debatable assertions: "Intellectual, moral, and spiritual precocity has never been conducive to the highest flower of the moral self." (Page 83.) "It is true that such a departure [of a highly moral man from the paths of integrity] from virtue may never be adequately accounted for, but if an accurate analysis of the delinquent's motives could be had, it would be found that there had been a substitution of immoral for

moral motives." (Pages 95–96.) One should rather look first for organic brain disease. Surely the psychiatrist has a different point of view. "The child who is not required, during the early years of life, to perform definite, set tasks over long periods of time, even though such tasks be mechanical in nature, will probably never develop a genuine sense of economic responsibility. Such a conclusion as this is more than mere theory; it is an established, concrete fact." (Page 121.) "When we tell the truth or are virtuous simply because cold intellect requires it, virtue has already lost some of its reward." (Page 167.) On page 237, a paragraph is devoted to the statement that change in belief is dangerous. I should hold the converse to be the case. On page 239, we find: "Too much moral and religious brooding is a real actuating agency for what is sometimes known as psychasthenia." Here he comes into my own field, where the assertion is safe that such moral and religious brooding is a symptom and not a cause.

Almost every page contains some example of this kind. What the book may be worth in the field of morals is beyond my capacity to judge, but from the standpoint of the problems of practical living as we encounter them in psychiatry, it is of little value. It is not permissible to write a counter thesis in a review, but surely the condemnation or approval implied in moral judgments as here conceived would be a handicap in understanding life as we see it objectively and in reality. From the mental-hygiene point of view the attitude toward child guidance alone would be sufficient to condemn the book. "The only true maxim would be never to permit the child to look upon the bad. The mere percept may be more powerful in the establishment of associations in its favor than any number of moral maxims to the contrary." (Page 157.) We are familiar enough with the results of careful shelter from the realities in early life. What happens to the unprepared adolescent when he encounters reality?

Colorado Psychopathic Hospital. LAWRENCE F. WOOLLEY.

MODERN YOUTH AND MARRIAGE. By Henry Neumann. New York: D. Appleton and Company, 1928. 148 p.

In this book Dr. Neumann has undertaken to answer the advocates of "companionate marriage". He meets "with frankness and fairness" the challenge of their claims that youth refuses to be "chained" by marriage; that, "capable of just as much loyalty as ever before, they want to be, as they say, unforced"; that permanence in marriage is no longer regarded as essential. He calls this "the new problem raised by this age of freedom and revolt".

The titles of his six chapters indicate the development of his argument: *The Revolt, Why Monogamy? Romantic Illusions, What Naturalism Overlooks, Plea for Privacy,* and *Preparations.*

The chief themes in Dr. Neumann's discussion are youth's desire for and interpretation of freedom and responsibility. He does not believe that man can live unto himself alone.

Youth seems to have pushed aside romance and duty as illusions. It wants nothing less than facts—truth, naked and unafraid, though "there are new vagaries as well as new truths. Their newness does not make them true." Human beings cling to illusions, however, and youth has fantastically picked out freedom, the so-called freedom of having your way, doing what you please, when you please, and as you please, not comprehending that such freedom is the greatest illusion of all. "It is hard to see", he says, "how people can be human and free on any other terms than those of self-control." And, again, "All freedom worth having is won by accepting life's limitations understandingly."

The heart of the problem is the question, "What shall freedom mean?" We are not free merely because we reach the age when we can no longer be coerced. "The more one is at liberty to go his own way, the greater is the responsibility to prove that he can go sensibly. Every lifting of outward restrictions requires all the more control from within." "The real problem of liberty begins only at the point where external pressure has been lifted." "The fundamental question is not at all whether one is going to be bound or be free. It is the more practical question by what we are to be bound—by the undisciplined, capricious part of us, or by the good sense which marks the higher life."

He sets forth the difficulties besetting marriage, both personal and economic, and some of the many reasons why people marry.

He attacks companionate marriage as an attempt "to build up a so-called new ethics out of people's weakness. It offends because it looks ultimately in the direction of sanctioning indulgence rather than promoting control." He repudiates as false the idea that "the best which people can get out of their relations with each other is pleasure".

That youth cannot be coerced, but must be persuaded, and that the way to persuade is "that of making the better way appeal on its merits as the better", Dr. Neumann is convinced. To him there is no doubt as to the better way. He puts clearly before us his reasons for his belief in the possibilities of successful marriage, which he calls "a priceless training". He believes in self-discipline, in character, in

the joy of shouldering responsibility. "It will be a pitifully flabby world where responsibility is put anywhere but first."

He states, "What these pages desire to stress, therefore, is rather the crying need for ethical preparation before marriage and the sound education required, and permanently so, ever after." He believes that preparation for marriage begins in babyhood.

Dr. Neumann is both an idealist and an optimist. "Youth has begun to think for itself without fear." His style is terse and temptingly quotable. He has the gift of humor. His arguments are not new, but they are well marshalled and his book is well worth reading more than once.

What new solutions the coming generations will find to these old problems we cannot know. The older generations warn, the younger dance and yawn, and the world's still at its dawn.

EDITH N. BURLEIGH.

Child Guidance Clinic,
Los Angeles and Pasadena.

THE EDUCATION OF THE MODERN BOY. By Alfred E. Stearns, Samuel S. Drury, Endicott Peabody, R. Heber Howe, W. Q. W. Field, and William G. Thayer. Boston: Houghton Mifflin Company, 1928. 271 p.

A more specific title for this volume would be *The Education of the Modern Boy During His Boarding-school Years.* The subject matter deals almost exclusively with the boy between the years of twelve and eighteen, and concerns the boy in the private preparatory school. Very little is said about his education prior to his twelfth year, and even the chapter on home influence, which is one of the best in the book, does not take into account those earlier formative years which have so much to do with what the boy really is when he enters boarding school. Dr. Gesell has said that education begins at birth, and psychologists and psychiatrists, as well as educators, are realizing more and more that the first six years of life are of tremendous importance in education, providing education is considered as the development of proper habits of thought, emotional responses, and behavior, and not so much as the memorizing of Latin and history dates. In spite of the statement in the last chapter that "the vital period in education is that covered by the years from twelve to eighteen", it seems that the title should be more specific, so that it will not be misleading.

It is rather interesting to note that the chapter on athletic influence is the longest in the book, while the briefest chapter is that on academic influence. Perhaps athletic coaches and others concerned

would say that this proportion is as it should be, and it does seem that the section devoted to athletic influence contains many more practical suggestions on the subject of character building than are to be found under any of the other titles, with the possible exception of Stearns's contribution on home influence. The future trend of the private school away from the "prep school" idea and toward the goal of making the most of the inherent freedom of the private school seems to be one of the most important ideas formulated in the book.

The introduction warns us that "the voice of the headmaster is authoritatively heard", but we could not ask for better authority than is heard in this book. The articles collected here should meet a need that parents of the adolescent boy have felt and recognized for some time. If other educators dealing with boys in other years and situations, from the nursery school through college, would compile a similar work, and if the psychologist and psychiatrist would add their contributions, we should have a fairly comprehensive view of the education of the modern boy. Needless to say, the education of the modern girl should be given the same consideration. Let us hope that the example of these men will be followed by others concerned with this important problem.

LLOYD H. THOMPSON.

Yale University.

INTRODUCTION TO SOCIAL STATISTICS. By Clarence G. Dittmer. Chicago: A. W. Shaw Company, 1926. 167 p.

The key to this work may be found in the preface, where the author states that his readers are expected to be "sociology students . . . few of whom will ever become professional statisticians," but all of whom "will have to deal with statistical studies and present their findings in an intelligible manner. He has in mind also the army of social workers who are expected to deal with facts rather than fancies." Most data used by statisticians are in all probability gathered in the field by just such individuals. Consequently it is well that they be versed in the procedures of gathering facts and arranging them systematically.

The greater part of the book is devoted to this end. There are chapters on the art of the statistical schedule and the subsequent tabulation of data drawn from the schedule. This is followed by a lengthy chapter on graphic presentation. There is a great deal of illustrative matter in the latter chapter, some of it good, more of it poor. The author's reason for the selection of data is that he desires his students to exercise critical judgment upon them. It is questionable, however, whether the elementary type of student for whom

the book is intended is in a position to analyze and recognize those psychiatric principles which enhance the value of one type of graph and detract from that of others.

The defect of the book lies in its assumption that sociology students have no more than a modicum of mathematical knowledge. Most of the users of this book, we are told, will have long since forgotten their algebra and most of them would be completely stumped by a problem involving the extraction of square root. To the reviewer this appears to be a severe indictment of the student rather than a justification of oversimplification of text. It seems, on the contrary, that the principles found in the average college textbook on statistics should be well within the grasp of every one who has had even the elementary courses in algebra required in high school.

The chapter on correlation is disappointing in that the student is shown how to find the coefficient of correlation from a paired series, but is left in the dark with respect to the treatment of the correlation table, which is the more usual arrangement. Again, there is no reason why the long-established term "coefficient of variation" should be abandoned for the coefficient of standard deviation, especially in view of the fact that the former is the recognized expression for the well-known measure of dispersion.

On the whole, it may be said that had the author kept in mind a higher type of student, the result would probably have been a more adequate text. At present the reader will profit most by the discussion of the presentation rather than the analyses of statistical data.

BENJAMIN MALZBERG.

New York State Department of Charities.

CHILD CARE AND TRAINING. By The Institute of Child Welfare. Minneapolis: University of Minnesota Press, 1928. 180 p.

There is no need to justify the publication of a book on child care and training. The field is such an important one, and there have been so few well-rounded attempts to meet the need for information with regard to it, that various approaches may be presented without fear of cluttering the market, while the experience gained from these various approaches is valuable.

In this book the staff of the Institute of Child Welfare at the University of Minnesota has brought together much generally accepted material, adding observations made at the institute itself. The book is a compilation of the individual discussions of an extension course, which is apparently so well organized that one is not conscious of gaps. The material is presented in a way that should make it comprehensible

to the average parent in comfortable circumstances, and the suggestions given are readily applicable to a parent at this social level.

Perhaps the greatest compliment that can be paid to this book is to state that the criticisms arising from a careful study of it are relatively few and for the most part of no great importance. The suggestion might be made that a great deal of already published material could have been added with advantage to the bibliographies presented. Also, it is to be regretted that such neurological terms as "nervous", "connections in the nervous system", and "nervous exhaustion" were not omitted in favor of the straight facts of behavior that they are supposed to represent.

The book is quite concrete and practical in that it suggests definite steps to be taken and things to be done. In the chapters on play and reading, specific articles are listed, so that the reader should have no difficulty in following out the more general suggestions. The book should be of value to the parent in helping him to prevent future trouble for the child and for himself. When serious problems have arisen, other approaches to these problems will have to be sought.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

GUIDANCE FOR COLLEGE WOMEN. By Mabelle Babcock Blake. New York: D. Appleton and Company, 1926. 280 p.

In his introduction to this book, President Neilson, of Smith College, says: "The most promising element in the educational movement of the present day is the *rediscovery of the individual student.*"

It is unfortunately true that in the development of mass education, administrators have been so concerned with curriculum, the raising of funds, advertising propaganda, and school policies that the real function of education has been almost obscured. In fact, the function of education needs to be redefined since the democratization of higher education. We are just coming through a period in which the attitude of the country as a whole toward higher education has been: "College for every one if possible." Critical minds have attacked this thesis, and much literature has been published on the question of cultural versus vocational education. Experimental psychologists have focused attention on individual differences to such an extent that one would no longer dare prescribe the same kind of educational opportunities for all students.

Not only is the line being drawn more sharply between those who ought to go to college and those who ought to learn a trade or pursue some definite vocation for which a college training is not necessary, but vocational guidance in college has been creeping in

more and more as a problem to be reckoned with. One sees only too frequently the sad picture of the educated youth, with his diploma tucked under his arm and a high idea of his accomplishments, who becomes a constant source of irritation to any industry because of his complete lack of information on practical subjects or training along practical lines.

In women's colleges especially a need has been felt for the formulation of final aims in education. Too many young women have gone to college because it was the mode, and without any intention of ever doing anything with their college education. However, as a result of increased difficulty of entrance, the introduction of intelligence tests, and long waiting lines, students as well as colleges have had to focus attention more directly upon what one expects to get out of a college education. "Culture" alone is no longer an adequate answer.

In her book, Dr. Blake, who is personnel director at Smith College, gives a comprehensive survey of the various methods of meeting this need in colleges for women scattered all over the United States. There are some special cases that serve to bring to mind clearly and specifically the varied problems which the college student and the college administration must meet. The plans extend all the way from a mere cursory mass examination to careful, detailed studies of the individual student by a competent psychiatrist. The book is not only an excellent summary of what is being done, but is suggestive and helpful to any one who contemplates preparing personnel work in colleges. The appendices give samples of questionnaires sent to secondary schools and record forms for keeping information in the personnel office. There is also a complete bibliography covering material which is either directly or indirectly related to the vocational guidance of college students.

SADIE MYERS SHELLOW.

Psychological Department, The Milwaukee Electric Railway and Light Company.

NERVOUS AND MENTAL DISEASES FOR NURSES. By Irving J. Sands, M.D. Philadelphia: W. B. Saunders Company, 1928. 239 p.

This volume adds one more to the recent textbooks on nervous and mental diseases written for nurses. While in some respects the material is well presented, the general impression of the book does not allow one to recommend it.

The most important criticisms are as follows: There is considerable repetition of material. It does not seem necessary to present such conditions as general paresis, cerebral arteriosclerosis, and

the like under nervous diseases and then again under mental diseases. There are numerous errors and omissions throughout the book, and the attitude with regard to psychiatry is not one that the reviewer would advocate trying to teach our nurses at the present time.

In the chapter on elementary neuro-anatomy, the author states that all sensory tracts relay in the optic thalami. The olfactory pathway is specifically mentioned as doing this. The chapter on the glands of internal secretion can hardly be regarded as authoritative. Many things stated as facts are merely hypotheses. The discussion on the adrenal glands gives the impression that Addison's disease is produced largely by an involvement of the adrenal medulla and a diminished secretion of adrenalin. It is also stated that "the function of the parathyroid glands is to furnish to the blood a substance which renders harmless some poisons that exist in the body". There is no mention of parathormone or the function of the parathyroid glands in the control of calcium metabolism.

In the section on the forms of feeblemindedness, we are told that the average normal sixteen-year-old person has an intelligence quotient of 100 per cent; and in connection with trauma to the head, that if a fracture of the skull occurs, the patient is unconscious. Discussing epilepsy, the author startles us with the following expression of his opinion: "Furthermore, we personally do not believe in the theory that heredity plays the most important rôle in this disease; we have seen it in homes of the most intellectual and gifted people and even among royalty."

With regard to the treatment of mental diseases, the author varies from psychoanalysis to restraint, both of which receive his unqualified approval. In regard to psychoanalysis, we are told that the important thing is the abreaction; transference is not even mentioned. It is also somewhat difficult to reconcile the author's endorsement of psychoanalysis with the following statement: "We must never frighten a patient nor should we ever discuss any intense sexual situation with them."

The statement that depressed patients rarely attempt to drown themselves in a bath tub is not according to fact, and might cause nurses to be less careful and to take fewer precautions when bathing such patients. In the treatment of delirium tremens, we are told that the patient should be tied in bed. The continuous bath is not even mentioned. Restraint is constantly spoken of as a method of treatment, and the continuous bath and the pack are classified as forms of restraint. We are also told that a patient should never be kept in solitary confinement. Yet isolation by

secluding a patient in a room by himself is a measure employed in the best hospitals for mental diseases in this country. In the matter of the continuous bath, a nurse reading the book will be rather hopelessly confused as to the proper temperature. On page 183, "approximately 98°F" is stated to be the correct temperature. On page 228, a list of rules for the continuous bath are printed from which we learn that "the temperature of the water must not exceed 98°F and must not drop below 92°F, the ideal temperature being 96° F". On page 227, 95° to 100° F is given as correct. Further illustrations of the same sort might be cited.

We must conclude, therefore, that the book is too loosely and carelessly written and is full of too many errors and contradictions to be recommended as a textbook for nurses. From the psychiatric point of view, it does not seem to portray the best and most scientific methods.

KARL M. BOWMAN.

Boston Psychopathic Hospital.

SUICIDE PROBLEMS. By Frederick L. Hoffman. Newark: Prudential Insurance Company of America, 1927. 270 p.

This book, or large pamphlet, is for the most part a republication of statistical data gathered over many years by Dr. Hoffman, consulting statistician of the Prudential Insurance Company of America. Students of psychiatry and sociology have long been familiar with Dr. Hoffman's researches and will greet with a great deal of enthusiasm a volume that brings all of these together and thus furnishes a mine of statistical information.

The book deals for the most part with statistical tables gleaned from every corner of the world. Of particular interest are the suicide records of American cities running from 1896 to 1927. Dr. Hoffman finds that there is no longer an increase in suicide in America. Perhaps he does not attach enough importance to the influence of the war in checking the progressive increase in the suicide rate.

The introduction is largely concerned with the philosophy and ethics of suicide. This does not reflect a professional attitude toward the subject. For instance, in the discussion of one suicide, the statement is made that it probably would not have taken place had there been proper safeguards against the sale of dangerous weapons.

Although psychiatry is mentioned from time to time, it is practically ignored in the discussion of illustrative cases. Commonplace causes are sought. One man states that no cause could be assigned

for the act except that he suffered excruciating pains. The few cases cited with which the reviewer is familiar show a lack of understanding of the fundamental mental mechanisms back of suicide.

As a collection of statistical data, the book will always be of value; as a philosophical treatise on suicide, it will merely serve to perpetuate a lot of superstitions which advanced thinkers have long since rejected.

A. Warren Stearns.

Tufts Medical School.

Epilepsy; Comparative Pathogenesis, Symptoms, Treatment. By L. J. J. Muskens, M.D., with a foreword by Sir Charles S. Sherrington. New York: William Wood and Company, 1928. 650 p.

Dr. Muskens needs no other recommendation to those who are not familiar with his work than that given by Sir Charles Sherrington. In this monograph on epilepsy he has covered the field in thorough, painstaking manner. The first 194 pages are given over to a comprehensive review of the literature bearing on experimental investigation and the recording of his own laboratory investigations, while the second part of the book is concerned with clinical observations. This portion is of much more practical value to the physician. Part III is entitled *Epileptic Disorders Observed in Man and Their Treatment.*

Dr. Muskens' approach to the subject is that of the physiologist; he is obviously "organically minded". The entire monograph shows very clearly the influence that men like Hughlings Jackson, Gowers, and Horsley have exerted on his training, yet he has not ignored the psychogenic aspects of the convulsive disorders.

Some of the chapter headings will indicate how extensively he has covered the subject: Chapter V.—*Tonic Spasms and Convulsions in Childhood and Their Significance for the Development of Epilepsy;* Chapter VI.—*Influence of Menstruation and Pregnancy in the Occurrence of Epilepsy;* Chapter VIII.—*The Relative Frequency and Nosological Value of the Symptoms;* Chapter IX.—*The Statics of Epilepsy;* Chapter X.—*Differential Diagnosis;* Chapter XII.—*Treatment;* Chapter XIV.—*Traumatic Epilepsy and Surgical Treatment;* Chapter XV.—*A System for the Prevention of Epilepsy and for the Care of Epilepsy.*

Dr. Muskens has presented his subject in a most interesting and practical way. He has brought to bear a keen scientific mind in criticizing the contributions of others. One is impressed by the painstaking and detailed account of the experimental work recorded,

and by the fact that he obviously knows the epileptic as well as the condition we term as epilepsy. As a book both of reference and of practical value to the clinician, it can be highly recommended.

D. A. THOM.

Tufts Medical School.

CLINICAL AND ABNORMAL PSYCHOLOGY; A TEXTBOOK FOR EDUCATORS, PSYCHOLOGISTS, AND MENTAL-HYGIENE WORKERS. By J. E. Wallace Wallin. Boston: Houghton Mifflin Company, 1927. 649 p.

In this companion volume to the author's *The Education of Handicapped Children*, the emphasis is on "psychological methods and diagnostic technique with a consideration of the causes for and the educational implications of each type of mental defect". Whereas the purpose of the book is to present to the student a systematic "purview of the entire field" of clinical and abnormal psychology, it is avowedly "sympathetic toward a behavioristic approach". This is not to say, however, that it represents the point of view of an extremist; although the dynamic psychologies are by no means in the ascendant, neither are they disregarded. In accordance with Dr. Wallin's primary aim, both the structural and the dynamic concepts of human behavior are given a place as organized systems.

A threefold study of the individual is, in the opinion of the author, necessary to a complete understanding of a given problem. Accordingly, there are three divisions of subject matter into intelligence, motility, and emotivity. In each of these three sections, the main emphasis is on diagnostic measurement and the description of symptoms that mark the deviate. The consideration of causative factors is attempted from the physiological, structural, and dynamic points of view whenever possible, but it is obvious that more than a cursory consideration is impossible. One cannot but feel from time to time that too much material has been compressed into this volume; that either psychological methods and diagnostic technique, or causes for and educational implications of each type of mental defect, would be matter enough for one book; but that when both are included and the discussion of causation is furthermore multiplied fourfold by systematic treatment, issues become blurred even while the author's style is unmistakably clear and simple.

The student will find the chapters devoted to individual and group tests of intelligence particularly valuable. The presentation of controversial concepts of intelligence, the full evaluation of quantitative methods of measurement, and the highly socialized point of view from which the interpretation of test scores is considered, are

outstanding. The section on motility describes the physiological mechanisms that underlie motor abilities, as well as the test apparatus devised to measure them. The illustrations of physiological measuring instruments and of performance tests enhance the value of these chapters.

In the section on emotivity, the bulk of the material is concerned with objective examinations evaluated in so far as possible in the light of scientific research. The results are so at variance, so doubtful in their significance, that here more than elsewhere in the book one wishes for a thoroughgoing examination into the dynamic factors behind emotional response, personality traits, and character development. They are hinted at, but never explained in such a way as to relate, for example, the discussion of deviations in associative processes, imagery, and attention, which are categorically treated under intelligence, to the chapters on emotivity two hundred pages later. And yet had that been done, the non-diagnostic nature of most of the so-called tests of emotions and character would be self-explanatory.

While one admires greatly the practical qualities of the sections that deal with diagnostic technique, the academic air that marks the description and classification of pathological symptoms runs counter to the mental-hygienist's attempt to break through the crust and reach the core.

JEANETTE REGENSBURG.

New York School of Social Work.

THE ELEMENTS OF CRIME (PSYCHO-SOCIAL INTERPRETATION). By Boris Brasol. New York: Oxford University Press, 1927. 443 p.

In this volume Mr. Brasol, formerly prosecuting attorney to the St. Petersburg Supreme Court, attempts a very full and comprehensive inquiry into the nature and causes of crime, including an exhaustive examination of both social and personal factors.

The presentation is in two parts, the first dealing with crime as a "social phenomenon" and the second treating of its more significant "psycho-physical" implications. Introductions, it might be mentioned, are supplied by Professor John H. Wigmore and Dr. William A. White.

In the first section, after a preliminary introductory chapter, the author proceeds to a consideration of the following special topics: the genesis and nature of the criminal propensity, economic factors, religion and the family, education and the press, and problems of legislation and procedure. In this first part, emphasis is laid upon the important egocentricity component of the so-termed antisocial

tendency, this being characterized specifically by three qualities—disregard of social requirements, a "following of the line of least moral resistance", and lack of "remorse". Crime is finally defined by the author as "a deed, prohibited and punishable under the laws of a particular state, constituting a willful attempt on the part of the individual against the existing social order, and that factor which controls the coördination of the heterogeneous elements, of which society is the synthesis". In this connection, proper and necessary stress is given the causal multilaterality, so to speak, of criminal reaction and the importance of both immediate and remote factors, social, economic, and personal.

Brasol also makes some interesting comments on the possible unfavorable influence upon criminalism of "modernistic" tendencies within the church, and stresses the admittedly important relationship of the effects of family disintegration. Regarding the rôle of education, the author feels that there has been here a seriously detrimental neglect of essential religious, ethical, and æsthetic emphases.

As for the press, after careful and searching analysis, the conclusion is reached that, on the whole, the situation might be much worse. However, Mr. Brasol does point out a real need for continued and closer scrutiny of the type and volume of publicity given to crime. Thus he states: "From the standpoint of criminology the principal danger of perverted publicity is its ultimate demoralizing effect upon social psychology. Examined from this angle, indiscriminate journalism unquestionably occupies a prominent place among the factors which either cause or encourage the growth of the criminal propensity leading to the crystallization of the *'milieu criminel'*."

The discussion of personal or "psycho-physical" aspects is a full one, according merited significance to the criminogenic possibilities inherent in human nature and personality relations. In this connection, the personal element is very pertinently epitomized, thus: "the delinquent . . . is not only the author of the prohibited and punishable deed, but, as it were, a germ carrier of that antisocial energy, the discharge of which constitutes the crime itself". This is followed by a discussion of "responsibility", with some very interesting material bearing upon prevailing concepts and procedures, especially in certain European centers. There is further included a comprehensive description of the more important psychopathologic states, particularly in their relation to criminal and antisocial conduct.

To sum up, Mr. Brasol's book impresses the reviewer as a funda-

mentally sound and in some ways really interesting contribution, but at the same time it must be said that it adds but little to the concept of criminality as such. Also the effort to cover too much ground in the space available, and in too great prolixity of detail, definitely detracts from the clarity and readability of the work and therefore from its force and effectiveness.

THEOPHILE RAPHAEL.

Psychopathic Clinic,
Recorder's Court, Detroit.

AN INTRODUCTION TO FORENSIC PSYCHIATRY IN THE CRIMINAL COURTS. By W. Norwood East. New York: William Wood and Company, 1927. 381 p.

CRIME AND INSANITY. By W. C. Sullivan. New York: Longmans Green, and Company, 1924. 259 p.

These two books, both of them by Englishmen, are of a kind. Both of them attempt to adapt psychiatry to the requirements of the legal system as it stands. Both of them cite great numbers of cases to illustrate crime occurring in the course of and presumably as a direct manifestation of the various major psychotic entities. For this reason they afford interesting collections of criminal cases in which the "insanity" of the criminal is beyond serious question. Of the two, East—who is a lecturer on criminology at Maudsley Hospital and medical inspector of the prisons in England and Wales—gives much the more carefully selected and completely recorded cases.

Both of them sadly lack any evidence of having grasped the modern problems of criminology and of psychiatry as it relates to crime. Neither of them has anything to say about the actual motivation of crime, or the contributions of psychiatry in the improved disposal of the convicted criminal. Both of them assume that a guilty criminal goes either to jail or to the asylum—that it is a question of punishment or commitment. No other issues seem to have disturbed either author. The fact that a criminal whose antisocial propensities are the result of a personality upset of the type that is classifiable in the psychotic categories is relatively rare does not seem to have stimulated either author to attempt a broader view of the psychiatric aspects of crime.

So it stands that here we have two English books almost as bad, if not a little worse, than some of the recent American books on criminology written by psychiatrists. The English books are a little better in that their cases are better selected, but they are a little worse in that the American books have at least a broader conception of the field, even although few of them contribute much to a better understanding of it. It is quite significant and typical of both books that

Dr. Sullivan is described as being the medical superintendent of the Broadmoor *Criminal Lunatic Asylum.*

Topeka, Kansas. KARL A. MENNINGER.

THE INVERT. By "Anomaly". With an Introduction by Robert H. Thouless. London: Baillière, Tindall, and Cox, 1927. 159 p.

Books in English on sexual inversion are far from numerous, and there has long been a need and a demand for such a volume as *The Invert.* It fills most adequately the *lacuna* between the scientific work of Havelock Ellis and the literary presentations of John Addington Symonds and Edward Carpenter.

The Invert is, in the best sense, popularly written. It is addressed, as the author states, primarily to the sexual invert, and secondly to the normal reader. To the latter it should provide a basis for his better understanding of a sexual anomaly of which he probably knows little that is either correct or fair, but with which he sooner or later is likely to come into personal contact. And to the invert himself, and particularly to him who is bewildered or distressed or discouraged by his abnormality, the book will come as a very real comfort and help in his effort to orient himself, in work and in play, to a world that does not as yet recognize the invert as a useful and in many ways indispensable member of society. To many readers the book may appear unnecessary, so familiar with and tolerant to homosexuality have certain large sections of the public become; and it is to be feared that a great mass of educated people will never encounter this little volume. It is to be hoped, on the other hand, that it will reach teachers, doctors, clergymen, social workers, and business men, who, in their turn, may pass on to those with whose problems they are faced the excellent counsels to be found in *The Invert.*

"Anomaly" raises the usual questions as to the cause and nature of sexual inversion, its "cure", and its prevalence, all of which he wisely refrains from discussing in any detail. He makes one interesting plea, however: that later studies of inversion should not include bisexuality under the heading of true inversion, but should pursue an independent research. He feels that, while closely related, the two phenomena should be kept strictly separate in their scientific and social treatment.

The Invert should find its way into the libraries of all those who come in direct contact with numbers of their fellow men. It is a highly valuable, sane, and readable work by an invert—a fact that to the present reviewer only enhances and underlines, as it were, the wholly admirable motive for, and execution of, a long-looked-for book.

Providence, Rhode Island. S. RIGGS.

THE SMALL GENERAL HOSPITAL. By W. S. Rankin, H. Eldridge, and H. P. Van Arsdall. Charlotte, N. C.: The Trustees of The Duke Endowment. 77 p.

This monograph represents the collaboration of competent architects with well-known superintendents of general hospitals. It is excellently arranged and printed and contains architects' plans and illustrations in considerable detail, so as to be of the greatest possible use to those who are planning to build small general hospitals in the Carolinas. It would doubtless serve equally well in other climates, since it deals, not with those phases of construction that have to do with immediate climatic conditions, but rather with the arrangement of interiors and the fixed equipment. Its object is, first, to give information with regard to the general principles of hospital planning for the general public and non-technical groups; and second, to supply more detailed information and designs for the use of building committees and technical groups who are more directly concerned with the planning, designing, and building of hospitals. It is designed to be adaptable to the varying needs and conditions of different communities.

We find careful estimates of the number of beds that a hospital should provide for communities of given sizes in either rural or urban surroundings. There is even a note on the special conditions for which beds will be needed and the number required for each. These special conditions are contagious diseases, diseases of children, maternity cases, and tuberculosis. No mention is made of mental illness. Two assumptions are everywhere prevalent on this topic: one is that there is no mental illness in the community, because every case is or has been removed to some mental hospital maintained by the state; the other is that any patient with a mental disorder is disturbing to those who have no mental disorder, and therefore, no matter how many of such patients there be in the community, they should not be, and are not, admitted within the walls of the general hospital. Both assumptions are ludicrously false. As regards the first, it is well known that many families delay until the last possible minute the removal to the state hospital of the mentally ill among their members, either because of humiliation over the existence of a type of illness that is considered disgraceful, because of the distance of the mental hospital, or because of the feeling that those who go to a mental hospital can never be expected to improve sufficiently to come home again. As to the second assumption, all that is necessary to do is to examine the patients in any hospital ward to find that there are those among them whose problems are quite as much mental as physical.

Not many years ago the class of patients known as the tuberculous would have received as scant attention as mental patients do now; but tuberculosis is no longer considered a disgrace, and the principles of hospital treatment of the disease have been quite well established. There is need of the same process of education with regard to mental illness. Certainly, an early step toward reform in these matters is a recognition of the fact that problems of mental illness are all about us, are already found in the general hospitals.

Additions to the hospital in later years receive consideration in the monograph: enlargements for general hospital purposes, provision for cases of tuberculosis and infectious diseases, and nurses' home. Even in this matter of additions, no thought is given to the mental patient. Yet the prevalence of mental disorders is evident in the fact that the number of patients in mental hospitals in the United States is greater than the number in all the other hospitals combined.

An important chapter in the book deals with service relations, the theme being that traffic and service must be properly managed, else the hospital fails to function satisfactorily.

The second and larger section discusses the size, location, arrangement, and finish of the essential units of the hospital, and offers suggestions regarding workmanship and economies in construction. Lists are presented covering details of construction and finish and the furnishing and equipment of the various units. Each section begins with a brief statement of the purpose of the unit discussed. Future extensions of the institution receive appropriate consideration here.

The third section contains drawings, showing exteriors, interiors, and floor plans of buildings for hospitals of the various sizes in question.

To repeat, this is an admirable monograph. One only hopes that when it is revised, consideration will be given to a group of patients who in one way or another will find admission to the general hospital, but who are not so well provided for now as they should be.

SAMUEL W. HAMILTON.

Bloomingdale Hospital.

THE INFLUENCE OF MUSIC ON BEHAVIOR. By Charles M. Diserens. Princeton: Princeton University Press, 1926. 224 p.

This scholarly thesis, by the assistant professor of psychology at the University of Cincinnati, is an attractive presentation of a subject that touches psychiatry at several points. The author approaches music from the practical rather than from the æsthetic standpoint, he says, regarding it as a necessity, a possible means of reëducation and

human reconstruction, rather than as a mere subject of unproductive pleasure or an object for criticism from the learned few; and his method is both genetic and experimental. Considering music as including everything from the stridulating notes of insects through the most ambitious productions of the human vocal chord, he maintains that musical utterance is a eugenic factor. He gives measured approval to Darwin's view that musical tones and rhythm were first acquired for the sake of charming the opposite sex, but discusses war and work songs as well, and postulates that music comes from phylogenetic associations with two great primary impulses—the sex and the herd instincts.

In interesting anecdotal fashion he discusses the reaction of animals to music, a subject on which a considerable, but scattered mass of data exists. A chapter is devoted to myths about music and musicians, in which such well-known and widely distributed legends as those of the sirens, Orpheus, and the Pied Piper are reviewed and many less well-known are recalled to the reader's memory. The modern who has left a symphony concert with a feeling of rapture and awe, will not, perhaps, find it hard to understand how the ancients could think that sand was changed into diamonds, that haycocks stored themselves in barns, and that the rain was made to fall through the influence of music. Amphion's divine music raised the walls of Thebes and the divine minstrel of the Guianian Indians rescued despairing man from the deluge by the magic of his snake-skin drum, beating so rhythmically that the waters gradually sank delighted into the sea, and the rocks arose to listen.

There is an important chapter on "music in magic". Primitives are suffused with emotion through the mimetic and dramatic processes. They identify the force with the object, and distinguish two classes of stimuli—the natural and the mysterious. Hence, they mistake the order of their ideas for the order of nature, and imagine the same control for both. Primitive man had great confidence in the power of his wishes. Whatever evoked powerful movement thereby brought a feeling of omnipotence to its maximum; now this is one of the characteristic effects of music. Musical effects must have been greater on primitives than on the cultured, and musical images must have seemed to be objective realities. The author refers to certain data on colored hearing, which, he says, is less infrequent than is commonly supposed and may have played a rôle in the evolution of animistic philosophy. He notes, also, that a certain school of moderns has a complete scheme of identities of vowels, tones, colors, and abstract concepts; and several moderns compose according to magical principles.

The influence of music on work lends itself to more detailed obser-

vation and more careful experiment than music in the other fields just discussed. Primitives love idleness, but have to do much work in order to exist; and all over the world they sing as they work and thereby increase their activity. Civilized persons pursue the same course, perhaps less strikingly. Music stimulates nutritive processes, corrects poor posture, and by strengthening muscular contraction, increases the blood supply, promotes nutrition, and improves muscle tone. Experiments were made in this field as far back as the eighteenth century. Dr. Diserens also has carried out some carefully observed experiments in which he has used not isolated musical elements, but musical compositions; and has recorded the result on (1) habitual voluntary reactions, (2) voluntary reactions involving attention and judgment, and (3) involuntary reactions. His conclusions are carefully drawn and not overstated.

We speak last of his discussion of the influence of music on the sick, though in the volume this is a median chapter. The conception that there is a musical therapy dates from the remotest antiquity and is current among practically every primitive or semi-primitive people of to-day. Pythagoras directed that certain mental disorders be treated by music. Celsus, Coelius Aurelianus, and others are quoted. Arabian hospitals in the thirteenth century had music rooms with musicians constantly playing. Distinguished royal patients have been treated in this fashion and have at least professed to get great solace from the treatment. Most prescriptions have been general, and those who have taken the trouble to write about musical therapy have been inclined to claim more than present-day experience would seem to warrant, for we are disinclined to prescribe music for the cure of aphasia, apoplexy, epilepsy, and the like, as some older writers aver they have done. A plausible explanation offered is that the therapeutic effects of music are due to association. Certainly the revival of musical therapy indicates a belief that it actually produces favorable changes in the organism; and a relatively simple theory of its action is that by agreeably occupying the higher centers, music leaves the sympathetic nervous system free from interference. The chapter on musical therapy is largely anecdotal in character.

Let us leave this book with the statement that not only is it interesting to the casual reader, but it should be studied by those who are planning to make use of music in any way in relation to the sick. The reviewer ventures the hope that it will stimulate others to make careful observations of the use of music in hospitals for the mentally ill. Probably there are few hospitals that utilize music in the daily life of their patients nearly as fully as sound experience shows to be possible and desirable. Some one with a background of adequate

experience in the care of the mentally ill and adequate knowledge and appreciation of music should some day take up this theme and set forth in authoritative fashion what can and what cannot be accomplished in this field.

May we not hope that music, like other useful disciplines, may be developed into a therapeutic measure comparable to physiotherapy, athletics, and occupation therapy?

SAMUEL W. HAMILTON.

Bloomingdale Hospital.

MENTAL AND SCHOLASTIC TESTS. By Cyril Burt. London: P. S. King and Son, 1927. 432 p.

This is a third impression (November, 1927) apparently from the same plates, throughout, as the second impression (September, 1922), which was reviewed in MENTAL HYGIENE, July, 1924.

During an interim, in which this book was out of print, the publishers "reprinted" from it the *Handbook of Tests* of 106 pages, "with a new preface and instructions to teachers how to use the tests".

New York City. THOMAS H. HAINES.

PRACTICAL CLINICAL PSYCHIATRY FOR STUDENTS AND PRACTITIONERS. By Edward A. Strecker, M.D., and Franklin G. Ebaugh, M.D. (Second edition enlarged and revised with illustrations.) Philadelphia: P. Blakiston's Son and Company, 1928. 458 p.

Drs. Strecker and Ebaugh have made some splendid improvements in the second edition of their already valuable textbook *Clinical Psychiatry*. The case method of presentation not only pictures the various psychoses more clearly than a generalized discussion, but also emphasizes the individual variations and the importance of thorough study, not only of presenting symptoms, but of hereditary and environmental factors and the personality make-up of the individual before the psychosis.

In this edition this approach is aided by an excellent brief discussion of etiology, of the relationship of physique to type of personality, and in many instances by an introductory discussion before cases are presented.

Therapy is more fully described, especially in the addition of a detailed account of the malarial treatment of general paresis, with clinical summary of results.

The concise and sound advice regarding the handling of behavior problems in post-encephalitic children is forward-looking in its preventive emphasis.

Schizophrenia receives more adequate treatment in this volume than in the first edition, and the reviewer wonders why the chapter title was not changed from *Dementia Praecox* to the newer term, which is frequently used in the text and is admittedly more accurate and desirable.

The chapter on the psychoneuroses has been vastly improved by the addition of much case material and a fuller explanatory text.

It seems unfortunate that such a careful presentation of subject matter should not have been more carefully proof read so as to avoid the rather numerous omissions of letters and mistakes in punctuation. With these exceptions, however, the book deserves unqualified praise and recommendation for the student or practitioner who wishes a concise and accurate handbook of mental disease.

In conclusion, this second edition is a great improvement on a book whose first edition was excellent, so that we now have a concise and yet thorough treatment of clinical psychiatry. To me it now represents the best small book published upon clinical psychiatry.

ARTHUR H. RUGGLES.

Butler Hospital.

THE INNER WORLD OF CHILDHOOD; A STUDY IN ANALYTICAL PSYCHOLOGY. By Frances G. Wickes. New York: D. Appleton and Company, 1927. 372 p.

The contribution of the psychoanalyst to the understanding of the mental life of the child is becoming more and more illuminating. The author of *The Inner World of Childhood* has had considerable experience as a teacher. She shows strongly the influence of both Adler and Jung.

Aside from an analysis of the various abnormal manifestations on the part of the child from an orthodox analytical point of view, Mrs. Wickes gives a wealth of specific material drawn from her large experience. Of special note is her stress on the effect on the child of the undercurrent in the home. Attitudes and feelings repressed by the parent in order that the child may not suspect them are quickly sensed by the child. The author emphasizes the importance of the parents' straightening out their own difficulties satisfactorily in order that the child shall not bear the burden of his parents' maladjustment. There is a very good chapter on adolescence. Other topics discussed are imaginary companions, fear, sex, and dreams, and there is a final chapter on a correlation of dream and phantasy material.

There is very little in the book that is new to those who are familiar with the analytic point of view. The many short summaries serve to make the explanations more vivid. The style is easy and pleasant.

The book on the whole is a very good one to recommend to parents who are trying to understand the problems of their children.

SADIE MYERS SHELLOW.

Psychological Department, The Milwaukee Electric Railway and Light Company.

THE PROHIBITION MANIA. By Clarence Darrow and Victor S. Yarros. New York: Boni and Liveright, 1927. 254 p.

This very unsatisfactory book was written to refute the arguments set forth in Irving Fisher's book, *Prohibition at Its Worst*. In preparing their arguments the authors evidently did not deem it worth while to make a careful inquiry into the effects of the liquor traffic at any time, or into the effects of prohibition on the liquor traffic or on social welfare. The book presents practically nothing new and very little that has not been better stated elsewhere. It consists principally of unverified opinions, statements, and quotations of doubtful value. To one who seeks definite data on which to base conclusions, it is disappointing to find unsupported statements such as the following: "The great majority of civilized, educated, and cultivated people use liquor to-day." "The great majority of the men of science drink intoxicating beverages in moderation. . . . The same is true of the overwhelming majority of professional and business men." " The opponents of prohibition are not obscurantists or standpatters. On the contrary, they are among the most progressive elements of the population, who encourage and promote science and culture in every way, and if science should ever arrive at the definite conclusion that alcohol in any quantity is physically or morally and socially seriously injurious, they will be among the first to urge individuals to abstain from the use of alcohol." "There never were statistics of any value showing the relation between crime and intoxicating liquors. There is no appreciable relation and there never has been."

These few quotations give a sample of the authors' style and method of argument. There is throughout sharp criticism of Professor Fisher's deductions, but little constructive discussion.

Those who think that a great social question can be solved by a lawyer sitting at his desk and writing denunciatory statements concerning everything that interferes with his personal desires will naturally want to read this book; on the other hand, those who desire accurate information on the great problem of the control of the liquor traffic will have to look elsewhere.

HORATIO M. POLLOCK.

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THE EXAMINATION OF THE CENTRAL NERVOUS SYSTEM. By Donald Core, M.D. New York: William Wood and Company, 1928. 248 p.

This book was produced to assist the neurological student in developing a thorough and systematic method of examination of neurological cases. The author has kept to this purpose by relating clearly and in moderate detail the clinical symptoms produced by disease and the method of testing the integrity of the various components of the nervous system.

The major portion of the book is devoted to the description of a method of systematic neurological examination, and the technic for making the various tests is clearly explained. Emphasis throughout is placed on the clinical interpretation of symptoms. No attempt is made to establish syndromes for the various diseases, but symptoms are sufficiently discussed to illustrate the particular phases of examination under consideration. In like manner neuro-anatomy and neuro-physiology are but lightly touched upon. The chapters on the cranial nerves and on aphasia are particularly well done. The examination of the mental state of the patient is briefly outlined and is of value in as much as it relates the major clinical manifestations of psychic disturbances and tells what to look for. The diagnostic value of the X-ray, the cerebro-spinal fluid, and the blood pressure and the clinical significance of the more common pathological states are briefly discussed. The concluding chapters deal very briefly with the subject of differential diagnosis and, while incomplete, contain some valuable diagnostic hints.

The book is clearly written; it is easy to read and to understand. It deals with a phase of clinical neurology—the technic of examination—which is given but little consideration in the more complete texts of neurology and should, therefore, not only be of value to the neurological student, but should also assist the general practitioner in the detection of neurologic involvement.

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NOTES AND COMMENTS

Legislative Notes

The following summary of 1929 legislation is divided into two parts, bills that have become law and bills that failed. In each part the bills are indexed according to subject and listed alphabetically by state. Bills of purely technical or local interest are not listed. In the case of those that have become law, both the designation of the bill and the chapter of the law are given when known.

NEW LAWS

Index by Subject

Administration and Finance

Indiana S. 26; Maine S. 669; Massachusetts H. 1256; Montana H. 314; Nevada H. 187; New Hampshire H. 173; New York H. 800; S. 90, and S. 173; Oregon H. 573; Pennsylvania S. 5.

Commitment

Connecticut H. 409; Massachusetts S. 221; New York H. 800 and S. 646.

Criminal Insane

Montana H. 314.

Delinquent, Defective, Dependent, Psychopathic, and Maladjusted Children

Colorado H. 158; Iowa S. 174, and S. 175; New Jersey H. 207; New York H. 800 and S. 370; Ohio S. 172; Oregon H. 573.

Epileptics

New York S. 173.

Examination of Prisoners and of Certain Persons Accused of Crime

California S. 207; Delaware S. 33; New York H. 784.

Feebleminded, Care of

Nevada H. 160; Utah S. 51.

Guardianship

Maryland S. 72; New York H. 1052.

Insanity Pleas in Criminal Cases

California S. 207.

Marriage and Divorce

New York H. 787.

Miscellaneous

Minnesota S. 226; New York S. 553; U. S. Congress H. 16436.

New Institutions and Clinics

California H. 523; Montana H. 314; New York H. 784 and H. 1776; Pennsylvania S. 5; Utah S. 51 and S. 88.

Special Classes for Retarded Children

New York S. 370.

Sterilization
Arizona S. 34; Delaware S. 32 and S. 33; Maine S. 112; Michigan H. 203; Nebraska S. 197.
Veterans
Maryland S. 72; Michigan S. 274; Utah S. 3.
Voluntary and Emergency Admission
Connecticut H. 409; Rhode Island H. 909.

Arizona

S. 34. Provides for the sexual sterilization of any patient confined in the state hospital for the insane "afflicted with hereditary forms of insanity that are recurrent, idiocy, imbecility, feeblemindedness, or epilepsy". It should be noted that this act includes all of the above mentioned persons under state care, inasmuch as they are all confined in this institution.

California

H. 523, Chap. 683. Provides for the establishment of a state hospital for the insane in southern California.

S. 207, Chap. 385. Relates to insanity pleas in criminal cases. Summarized in April number of MENTAL HYGIENE.

Colorado

H. 158. Provides that no mental incompetent under the age of sixteen years shall be committed to the Colorado State Hospital in the event that the Ridge School, the Grand Junction Home, or the Colorado Psychopathic Hospital has accommodation for him.

Connecticut

H. 409. Amends Chapter 110 of the Public Acts of 1921 by providing that any person who has suddenly become in need of care and treatment in a hospital for the insane may be confined in such hospital, either public or private, for thirty days, rather than for twenty days, without order of any court, and that notification of both the emergency commitment and the court commitment, if this be found necessary, shall be made to the comptroller rather than to the department of state agencies and institutions, as formerly.

Delaware

S. 32. Amends the sterilization law by including the mental-hygiene clinic of the Delaware State Hospital at Farnhurst and the superintendent of said institution among those authorized to recommend sterilization.

S. 33. Amends the sterilization law by providing that "all habitual

or confirmed criminals who have been convicted of at least three felonies by any court of this state or of the United States, or of any other state, shall be subject to observation and examination by the mental-hygiene clinic, or the superintendent of the Delaware State Hospital at Farnhurst". If, on such observation and examination, it be found that any such person's criminality is caused by mental abnormality or mental disease, the board of trustees or other governing body, as the case may be, is authorized to apply to the state board of charities for the sterilization of such person.

Indiana

S. 26, Chap. 89. Permits the state to levy charges for the treatment of insane persons against the patient's estate if there are no near relatives.

Iowa

S. 174. Makes the penalty for contributing to juvenile dependency equal to that for contributing to juvenile delinquency.

S. 175. Amends the definition of dependent and neglected children by making it include any child who "is living in a home wherein because of carelessness or neglect of a person or persons having a transmissible disease of a serious nature . . . the health of the child may be in danger".

Maine

S. 112, Chap. 6. Amends the sterilization law by permitting the guardian to give consent in case the patient is mentally incompetent.

S. 669. Provides for the licensing and regulation of private hospitals and private houses for the treatment of patients mentally deranged.

Maryland

S. 72, Chap. 74. Provides for the guardianship of incompetent veterans and of minor children of disabled or deceased veterans, and makes uniform the laws pertaining thereto.

Massachusetts

H. 1256, Chap. 322. Authorizes the department of mental diseases to take or purchase land in the city of Waltham and the towns of Belmont and Lexington for the proposed Metropolitan State Hospital.

S. 221, Chap. 136. Provides for observation and commitment to federal hospitals for the insane.

Michigan

H. 203. Amends the sterilization law so as to permit of sterilization without consent of the patient, in case the patient is mentally incompetent.

S. 274. Provides for the guardianship of incompetent veterans, etc.

Minnesota

S. 226. Makes it a felony to abduct or carry away any feebleminded person committed to the guardianship of the state board of control from any institution or place.

Montana

H. 314. Appropriates the sum of $112,008.00 for the purpose of constructing, furnishing, and equipping a house for the criminal insane, living quarters for the attending physicians, and an addition to the heating plant at the Montana State Hospital for the Insane.

Nebraska

S. 197. Repeals certain sections of the sterilization law, notably that requiring consent of parent, guardian, or next of kin; provides for the sterilization of habitual criminals, permitting them, when sterilized, to appeal for parole after one year; and places the authority in such cases in the hands of the "board of control", this term being substituted for "examining board".

Nevada

H. 160. Provides for the care and education of feebleminded children, the expenses to be paid, when necessary, by the county of residence of the child. The county commissioners of the various counties are required to make all contracts and arrangements, which may be made with any responsible parties or institution, in or without the state of Nevada.

H. 187. Authorizes the board of capitol commissioners to make needed improvements and repairs upon the building and equipment of the Nevada State Hospital for Mental Diseases, and appropriates $19,500 therefor.

New Hampshire

H. 173. Appropriates $200,000 for the construction and equipment of a dormitory for disturbed male patients at the state hospital.

New Jersey

H. 207, Chap. 53. Amends the juvenile-courts act so as to permit municipalities maintaining no home for the detention of juvenile

offenders to contract with other municipalities maintaining such homes.

New York

H. 784, Chap. 242. Provides for a psychiatric clinic at Sing Sing Prison for a scientific study of each criminal and recommendations for the care, training, and employment of criminals.

H. 787, Chap. 537. Amends the domestic-relations law, in relation to the annulment of a marriage on the ground of incurable insanity, as follows: (1) provides for the filing and recording of the instrument creating the security for an insane wife's care and maintenance during life; (2) strikes out the provision that one of the three examining physicians shall be the superintendent of a state hospital for the insane, and provides that all three, instead of only two, of the examining physicians shall be appointed by the court; and (3) adds the following: "When a person alleged to be incurably insane is confined in a state hospital for the insane, one, and only one, of the physicians so appointed shall be a member of the resident medical staff of such hospital designated by the superintendent thereof. If the alleged incurably insane person is not confined in a state hospital for the insane, one of the examining physicians named in pursuance to this section shall be the superintendent of a state hospital for the insane."

H. 800, Chap. 136. Amends the mental-hygiene law by including the Court of Special Sessions of the City of New York among those agencies which may order commitment to an institution for mental defectives of a mentally defective person not over sixteen years of age who is charged with misdemeanor.

H. 1052, Chap. 335. Amends the real-property act by extending the requirement of appointment of a committee of property of an incompetent to include "a person incompetent to manage his affairs by reason of imbecility arising from old age or loss of memory and understanding".

H. 1776, Chap. 549. Establishes, in Suffolk County, a state hospital for the care and treatment of the insane, to be known as the Pilgrim State Hospital, "in recognition of the devotion of Charles Winfield Pilgrim to the care of the insane in New York State".

S. 90, chap. 63. Amends the mental-hygiene law by defining "resident" to be a person who has lived in the state at least one year "continuously".

S. 173, Chap. 550. Amends the mental-hygiene law relative to Craig Colony for Epileptics. Summarized in the April number of MENTAL HYGIENE.

S. 370, Chap. 258. Amends the education law by extending the

provision for special classes for retarded children to all such children rather than to those only who are three years or more retarded, and by placing the establishment of special classes under rules to be established by the state education department.

S. 553, Chap. 379. Authorizes the land board to surrender to the city of New York a part of the premises and structures on Ward's Island, now occupied by the Manhattan State Hospital.

S. 646, Chap. 172. Amends the mental-hygiene law relative to temporary and voluntary admission of mental defectives. Summarized in the April number of MENTAL HYGIENE.

Ohio

S. 172. Amends the general code relative to medical examinations in juvenile courts, so as to include examinations by psychiatrists and psychologists.

Oregon

H. 573, Chap. 416. Provides for the support of homeless, neglected, and abused children and indigent orphans under the age of sixteen years, cared for by benevolent or charitable institutions in Oregon, for the support of wayward girls, and for the care of maternity and venereal cases, appropriating money therefor, and declaring an emergency.

Pennsylvania

S. 5. Authorizes and regulates the establishment and operation by counties of hospitals for the treatment of women afflicted with nervous diseases.

Rhode Island

H. 909. Provides for emergency and voluntary admission of patients to the psychopathic ward of Providence City Hospital.

U. S. Congress

H. 16436, Act 935. Provides for the repatriation of insane American citizens in Canadian asylums.

Utah

S. 3. Pertains to the guardianship of incompetent veterans, etc.

S. 51. Provides for the establishment of the Utah State Training School for the Feebleminded.

S. 88. Provides for the establishment, maintenance, and control of "a home for fallen women".

BILLS THAT FAILED

Index by Subject.

Administration and Finance

Michigan S. J. R. 6; New York H. 1823; Washington S. 136 and S. 216.

Deportation

Maine H. 1543.

Guardianship

Pennsylvania H. 227.

Marriage and Divorce

Arkansas H. 139 and S. 65; Maryland H. 84.

Miscellaneous

New York H. 1160; U. S. S. 5602.

New Institutions and Clinics

Maryland S. 8; New York H. 1607; Texas H. 270; Washington S. 84.

Persons Accused of Crime

Maryland H. 496; New York H. 857.

Sterilization

Illinois H. 251; Missouri H. 290; New York H. 338; Oklahoma H. 422; Texas H. 399; Washington S. 220.

Arkansas

H. 139. Would make two years' confinement in a hospital for mental disease ground for divorce.

S. 65. Would fix the marriageable age of males at eighteen and of females at sixteen, and would require health certificates of both showing that they are not insane, idiots, or suffering from communicable diseases.

Illinois

H. 251. Would provide for the sterilization of inmates of state institutions for the insane, feebleminded, or mentally deficient.

Maine

H. 1543. Would provide for the deportation of alien criminals, paupers, and insane.

Maryland

H. 84. Would make hopeless insanity a ground for divorce.

H. 496. Would require examination of the mental condition of persons indicted for murder by a committee of the board of mental hygiene.

S. 8. Would create and establish, with an appropriation of $100,000, a state training school for feebleminded colored persons.

Michigan

S. J. R. 6. Proposed an amendment to the state constitution authorizing the state to borrow money for the purpose of building hospitals and asylums for the insane and other institutions.

Missouri

H. 290. Would provide for the sexual sterilization of feebleminded, epileptic, and insane persons and habitual criminals.

New York

H. 338. Would provide for sexual sterilization of the insane, feebleminded, and epileptic.

H. 857. Would amend the mental-hygiene law and the code of criminal procedure by creating in the department of mental hygiene a division for the examination of certain persons accused of crime. Summarized in the April number of MENTAL HYGIENE.

H. 1160. Relates to the certification of qualified psychiatrists. Summarized in the April number of MENTAL HYGIENE.

H. 1607. Would create a mental-hygiene clinic in the New York City Court of General Sessions.

H. 1823. Relates to the construction of buildings for the care, support, instruction, and training of wards of the state, state insane hospitals, and charitable institutions.

Oklahoma

H. 422. Would provide for the sexual sterilization of insane and feebleminded patients in state institutions.

Pennsylvania

H. 227. Relates to the protection of insane, feebleminded, and epileptic patients. Summarized in the April number of MENTAL HYGIENE.

Texas

H. 270. Would establish a state tuberculosis and epilepsy sanitarium for Negroes.

H. 399. Would provide for the sterilization of inmates in state institutions for the insane, feebleminded, and epileptic.

U. S. Congress

S. 5602. Would provide for the transfer of insane American citizens in foreign countries to St. Elizabeths Hospital at Washington.

Washington

S. 84. Would establish a state institution for the feebleminded.

S. 136. Would provide for a state board of public welfare.

S. 216. Would create a children's code commission to study child welfare, etc.

S. 220. Would provide for the sexual sterilization "of certain potential parents carrying degenerate hereditary qualities".

The Thomas W. Salmon Memorial

Plans have been perfected for a memorial to the late Dr. Thomas W. Salmon, former professor of psychiatry at Columbia University and Medical Director of The National Committee for Mental Hygiene. These plans call for the creation of an endowment fund of $100,000 or more, the income from which is to be devoted to an annual lecture or series of lectures to be known as The Thomas W. Salmon Memorial Lectures, to be given by authorities in psychiatry and mental hygiene for the purpose of advancing knowledge in these fields.

The administration of the memorial and the custody of the fund will be vested in the New York Academy of Medicine which will coöperate with a special psychiatric committee to be appointed for the purpose of selecting the lecturers, the topics to be presented, and the places where the lectures are to be given. Provision will be made for the publication of the lectures from year to year in leading periodicals and in book form.

The project was launched by a national committee composed of leading psychiatrists, neurologists, psychologists, nurses, social workers, educators, and mental-hygiene workers throughout the country who have undertaken to raise the fund by popular subscription. In its announcement of the plan this committee made the following statement:

"Psychiatry and mental hygiene have never had the benefit of this type of lecture provision which may well be the means of furthering knowledge in an important field and is, at the same time, particularly suited to the aims of the memorial.

"Such lectures will serve as an inspiration and incentive for the production of notable and distinctive contributions to the aims and purposes that were so nobly exemplified in Dr. Salmon's personality and career. They will have the merit of stimulating original work in every sector of the broad field of psychiatry and mental hygiene. They will turn the attention of students to difficult problems now pressing for solution and will encourage investigations and studies that may lead to discoveries of great scientific and social significance.

"Finally, by their publication and distribution from year to year,

these lectures will achieve a value and influence that will extend beyond the lecture hall and be nation-wide in their educational effects. In this way The Thomas W. Salmon Memorial Lectures may readily become an outstanding event of the year in the scientific world."

The officers of the memorial are as follows: *Honorary Chairman,* Hon. George W. Wickersham; *Honorary Vice-Chairmen,* General John J. Pershing, Dr. Nicholas Murray Butler, Rev. Harry Emerson Fosdick, D.D., Mrs. Helen Hartley Jenkins, and Dr. John H. Finley; *Chairman,* Frankwood E. Williams, M.D.; *Vice-Chairman,* William L. Russell, M.D.; *Secretary,* Austen Fox Riggs, M.D.; *Assistant Secretary,* Paul O. Komora, Esq.; *Treasurer,* The New York Trust Company; and *Assistant Treasurer,* Samuel W. Hamilton, M.D.

Checks should be drawn to The Thomas William Salmon Memorial, Inc., and sent to Dr. Samuel W. Hamilton, Assistant Treasurer, 370 Seventh Avenue, New York, N. Y.

Venereal Disease Among State Prisoners

The following statistics with regard to the incidence of venereal disease among the prisoners at the California State Prison at San Quentin appeared in a recent number of the *Journal of the American Medical Association.* They were contributed by Dr. L. L. Stanley, resident physician at the prison.

Every prisoner who enters San Quentin is given a thorough physical examination, including the Wassermann test for syphilis. During the period from January 1, 1918, to January 1, 1926, 10,000 men were thus examined. Of these men, 8,004, or 80 per cent, were white; 530, or 5.3 per cent, Negroes; 1,265, or 12.65 per cent, Mexicans; and 201, or 2 per cent, yellow.

Positive Wassermann reactions were obtained from 921, or 9.21 per cent of the 10,000. This group was made up of 578, or 7.2 per cent, of the white men; 96, or 18.1 per cent, of the Negroes; 198, or 15.6 per cent, of the Mexicans; and 49, or 24.3 per cent, of the yellow race.

A history of venereal sore which may have been chancre, chancroid, herpes, or venereal wart was obtained in the case of 1,507, or 15 per cent, of the 10,000, while 4,820, or 48.2 per cent, gave a history of gonorrhea that could not well be mistaken.

Of the 10,000 prisoners, 36.58 per cent were married and 63.42 per cent single.

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